

ADRIENNE C. SABIN, D.P.M.
560 E. ST. JOHN STREET
SAN JOSE, CA 95112
408-275-9200

Today's date _____

Co-pay: You are responsible for your co-pay **TODAY** at the time of your visit.

Deductible: You are responsible for your deductible if you have one.

Remaining Balance: You are responsible for your remaining balance after your insurance has paid.

We will bill your insurance as a courtesy to you, if your insurance does not pay within 60 days, the balance will be billed to you and is due at that time. You may pursue reimbursement from your insurance company.

Have you moved? No _____ Yes _____ New address _____

Do you have a new phone number? No _____ Yes _____ New phone # _____

Has your insurance changed? No _____ Yes _____ If yes, please show us your new card.

Primary Doctor _____

Last visit to Primary Doctor _____

I authorize the release of any medical or other information necessary to process the claim for this visit. I also authorize payment of medical benefits (including government benefits) to Adrienne C. Sabin, DPM for services described for this visit.

PATIENT'S SIGNATURE _____

Relationship to patient _____
(If patient is a minor or unable to sign)

Office Use Only _____

Notes _____ Letter _____ Billed _____ Payment _____ Orthotics _____ PT _____ Labs/X-ray _____ Ins Ck. _____ Recall _____