ORTHOTICS & PROSTHETICS EAST, INC
1025 W.H. Smith Blvd., Suite 108
GREENVILLE, NC 27834
TELEPHONE: (252) 215-2215 FAX: (252) 215-2216

REGISTRATION
PLEASE PRINT

_____ (____) _____ (____)_____ (____)_____
DATE HOME PHONE CELL PHONE WORK NUMBER

_____ _____
LAST NAME FIRST NAME MIDDLE INITIAL E-MAIL ADDRESS

_____
MAILING ADDRESS CITY STATE ZIP

☐ MALE ☐ FEMALE _____-_____-_____ _____ _____
SOCIAL SECURITY NUMBER BIRTHDATE AGE

☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED ☐ PARTNERED

_____ _____ (____)_____
PRIMARY DOCTORS NAME OFFICE NAME PHONE NUMBER

EMPLOYMENT INFORMATION

☐ EMPLOYED ☐ RETIRED ☐ DISABILITY ☐ UNEMPLOYED ☐ STUDENT

_____
EMPLOYER NAME OCCUPATION

INSURANCE INFORMATION

(PLEASE NOTE THAT PAYMENT IS DUE UPON SERVICES RENDERED)

_____
PRIMARY INSURANCE CARRIER ID NUMBER GROUP NUMBER

_____
SECONDARY INSURANCE CARRIER ID NUMBER GROUP NUMBER

_____
TERCIERY INSURANCE CARRIER ID NUMBER GROUP NUMBER

Policy Holder Information- Please include if you are not the primary card holder on the policy.

_____
NAME RELATION TO PATIENT SOCIAL SECURITY NUMBER DATE OF BIRTH

EMERGENCY CONTACT INFORMATION

(Please list number other than the ones listed above)

_____
NAME RELATION TO PAITENT

(____)_____ ☐CELL ☐HOME ☐WORK (____)_____ ☐CELL ☐HOME ☐WORK

AUTHORIZATION INSURANCE RELEASE AND PAYMENT

I certify that I do have coverage with _____ and assign directly to Orthotics and Prosthetics East, Inc., R. Shane Coltrain, BS, CPO, and all benefits, if any, otherwise are payable for the services rendered at OPE. I understand that I am financially responsible for all charges whether or not paid by insurance. This consent will end after one year from the date that this has been signed.

The above practitioner may use my healthcare information and may disclose such information to the above listed insurance company(ies) and their agents for the purpose of obtaining payment for services and determining benefits. This consent will end one year from the date of signage.

Medicare/Medicaid/Medigap Authorization: I request that payment be authorized and paid on my behalf to OPE for the services furnished to me by the practitioner. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any Information needed to determine these benefits for related services.

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PATIENT ACKNOWLEDGEMENT FORM

As part of the admission process, you will be receiving information on several policies and procedures that we have implemented to ensure your treatment while in our care is of the highest quality. This acknowledgement indicates your receipt of such information at the time of your initial registration or patient contact.

***Please put your initials on each of the blank lines as well as circle an answer for the three questions at the bottom of the page.**

_____ **Patient Bill of Rights** – This details your rights as a patient.

_____ **Warranty Policy** – Describes **Orthotics & Prosthetics East Inc.** policies with respect to warranty period and repairs/adjustments.

_____ **Payment and Policy Agreement** – This explains **Orthotics & Prosthetics East Inc.** policies with respect to billing your insurance and collecting applicable co-pays and deductibles.

_____ **Urgent Care** – Informs you of our urgent care procedures.

_____ **Patient Complaint Process** – This notifies you of our complaint and resolution process.

_____ **Medicare Supplier Standards** – Outlines standards that are to be maintained by **Orthotics & Prosthetics East Inc.** as a Medicare provider.

_____ **Consent to Treat**– I hereby authorize **Orthotics & Prosthetics East Inc.** to provide requested orthotic and/or prosthetic services.

_____ **Assignment of Benefits** - I hereby authorize **Orthotics & Prosthetics East Inc.** to release necessary medical information to my insurance carrier(s) to process my medical claim. I also authorize my insurance carrier to pay benefits directly to **Orthotics & Prosthetics East Inc.**

_____ **Acknowledgement of Receipt of Notice of Privacy Practices -** I certify that I have received a copy of **Orthotics & Prosthetics East Inc.** Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of **Orthotics & Prosthetics East Inc.** health care operations. The Notice of Privacy Practices also describes my rights and **Orthotics & Prosthetics East Inc.** duties with respect to my protected health information. The Notice of Privacy Practices is posted on our waiting room wall and on **Orthotics & Prosthetics East Inc**. website at **www.oandpeast.com. Orthotics & Prosthetics East Inc.** reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, asking for one at the time of my next appointment, or accessing the **Orthotics & Prosthetics East Inc.** website.

YES / NO Have you received a like or similar device within the last 5 years from either **Orthotics & Prosthetics East Inc.** or any other provider?

YES / NO Are you currently residing in a nursing home?

YES / NO Do you have surgery scheduled to treat the same condition for which this device will be utilized?

I request that payment of authorized Medicare and/or other insurance benefits be made to **Orthotics & Prosthetics East Inc.** on my behalf for any services furnished to me by **Orthotics & Prosthetics East Inc.** I authorize anyone who holds medical or other information about me to release that information to the Centers for Medicare and Medicaid Services and/or my insurance company and its agents in order to determine these benefits or benefits for related services.

I, the undersigned, have received, read and understand these policies and agreements and hereby consent to the above as indicated by my initials. I also attest that the above questions have been answered truthfully to the best of my knowledge.