Orthotics & Prosthetics East Inc.

PATIENT INFORMATION FORM

Social Security#: ___ - ___ - ___

(Mr. Mrs. Ms.) Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone# :( ) _____ Cell# :( ) _____ Married? Y/N

Parent/Guardian Name: _____

Emergency Contact Name: _____ Phone# :( ) _____ Relationship To Patient: _____

Can we text mobile #?: Yes No Leave Voice Mail Yes No

Employer Name: _____ Work#: ( ) _____

Email Address: _____ Would you like us to e-mail you appointment reminders? Y/N

Medical History:

Referring Physician: _____ Primary Physician: _____

Are you Diabetic? Y/N Name of Diabetic Physician: _____ Phone Number# :( ) _____

Insurance Information:

Primary Insurance Name: _____ Policy #: _____

Seconday Insurance Name: _____ Policy #: _____

PLEASE PROVIDE RECEPTIONIST WITH YOUR INSURANCE CARDS AND PHOTO ID

Have you received an orthotic or prosthetic device in the last 5 years? Yes No

Living In A Nursing Facility: Yes No

Have you receive a motorized wheel chair through insurance? Yes No

Worker's Compensation:

Ins Company: _____ Phone Number: ( ) _____ Claim Number: _____

Date of Injury: _____ Claims Adjuster: _____ Employer: _____

AUTHORIZATION TO ASSIGN BENEFITS TO PROVIDER & RELEASE OF MEDICAL INFORMATION:

I request that payment of authorized Medicare, Medicaid, Private Insurance and Other Benefits be made on my behalf to the above company for products and services that they have provided for me. I further authorize a copy of this agreement to be used in place of the original and authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid services and its Agents or Others, any information needed to determine these benefits or compliance with current health standards. I acknowledge having received or been offered a copy of Orthotics & Prosthetics East Inc.'s 1) Notice of Privacy Policies, 2) Medicare Supplier Standards and 3) Financial Policy.

_____

Signature of Patient/ Responsible Party **Today's Date**

_____

Printed Name of Responsible Party **Relationship to Patient**

Orthotics & Prosthetics East Inc.
1035 W. H. Smith Blvd.
Suite 108
Greenville, NC 27834
(252) 215-2215

CUSTOMER INFORMATION CHECKLIST AND ACKNOWLEDGEMENT

☐ Customer Rights and Responsibilities (see separate handout)
☐ Medicare Supplier Standards (see separate handout)
☐ HIPAA Privacy Notice (see separate brochure)
☐ Acceptance of Services

I understand that by signing this agreement, I authorize provision of products and/or services to me by Orthotics & Prosthetics East. I also understand the products and services provided are prescribed by my physician and that it is necessary that I remain under the supervision of my attending physician during the course of care.

☐ Release of Information

I hereby authorize release to your company of any and all of my medical records pertaining to my medical history, services rendered, or treatments received from my physician(s) or hospital. In order to process insurance claims, I also hereby authorize Orthotics & Prosthetics East to furnish my insurance carriers(s), and medical history, services rendered, or treatment needed. I further authorize Orthotics & Prosthetics East, the accreditation organizations, and other licensing bodies to periodically examine my records for the purpose of checking compliance to regulations and quality assurance requirements.

☐ Assignment of Benefits

I authorize direct payment of insurance benefits by my insurance company to Orthotics & Prosthetics East. In the event that my insurance carrier does not accept assignments of benefits, I understand that my payments may be sent directly to me and that I am obligated to endorse and directly send such payments to Orthotics & Prosthetics East.

☐ Financial Responsibility

I understand and I acknowledge that I am responsible to Orthotics & Prosthetics East for all charges not covered by my insurance. I recognize that in the event that my insurance company, employer, or any other third-party payer refuses to pay the rental and/or purchase price(s) of the received items, or delayed payments beyond 90 days of my receipt of items, or in the event that I have no insurance coverage or third-party payer, that I will be responsible for said payments and will make prompt reimbursement within 30 days of notification by Orthotics & Prosthetics East for all charges.*Orthotics & Prosthetics cannot guarantee patient insurance benefits including but not limited to coinsurance and deductible amounts provided by insurance and it is the patient's responsibility to verify their own benefits.*

☐ Equipment Warranty Information and Return Policy

Since orthoses and prostheses are prescribed at the direction of a physician, and are custom fabricated for the anatomy and medical condition of each individual, they cannot be returned for credit or refund. Prescribed "off the shelf" items cannot be returned for hygienic reasons. All custom devices are billable after fabrication process.

☐ Complaint Policy

All customers have the right to lodge complaints without fear of discrimination or reprisal and to know the disposition of complaints. Orthotics & Prosthetics East has the responsibility to respond to those complaints promptly and to resolve complaints whenever possible to the satisfaction of the individual.

☐ Custom Orthotics and Braces

Custom orthotics and braces will be billed at the time of delivery. In the event I do not pick them up when ready, I understand they will be billed to my insurance or me, if my insurance does not pay I am responsible.

☐ Change In Insurance Benefits and Coverage

I understand it is my responsibly to disclose any changes to my medical insurance coverage or benefits to Orthotics & Prosthetics at the time of the measurement. I understand by signing I am stating to my knowledge there are no changes in my insurance.

☐ I understand Orthotics & Prosthetics East' delivery and follow-up procedures

I acknowledge, understand and receive the entire contents of this document.

Patient Signature	Date	Print Name
Signature of authorized representative for patient	Date	Print Name

Parent/Guardian MPOA
Other: _____