The Orthotic & Prosthetic Centers

Patient Information

Name _____ Male / Female Date of Birth _____

Home Address _____

City _____ State _____ Zip _____

Mailing Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Best Phone to Reach You _____ Best Time to Reach You Between 9 and 5 _____

SS# _____ Marital Status _____ Email _____

Diagnosis _____ Do you have Diabetes? YES / NO

Physician Information

Referring Physician _____ Phone _____

Primary Physician _____ Phone _____

☐ **Emergency Contact** ☐ **Responsible Party** (if different from patient) ☐ **Other**

Name _____ Date of Birth _____

Relationship to Patient _____ Email _____ Phone_____

Mailing Address _____

City _____ State _____ Zip _____

Insurance Information

Primary Insurance _____

Subscriber _____ Subscriber Employer _____

ID# _____ Group# _____

Secondary Insurance _____

Subscriber _____ Subscriber Employer _____

ID# _____ Group# _____

Other Insurance _____

ID# _____ Group# _____

Worker's Compensation / Accident Information

Is this a Worker's Compensation claim? Yes / No Date of Injury _____

Claim Adjuster _____ Claim Number _____

Claim Adjuster Phone _____ Claim Adjuster Fax _____

Assignment Of Benefits

I attest the above information is correct. I authorize The Orthotic and Prosthetic Centers to release necessary information to my insurance carriers to process my medical claim. I also authorize my insurance carrier to pay benefits directly to The Orthotic and Prosthetic Centers. As the responsible party, I understand I am responsible for the entire amount of my claim and that insurance benefits may be limited or non-existent.

Signature _____ Relationship to Patient _____ Date _____

Patient Acknowledgement Form

The Orthotic & Prosthetic Centers

Patient Bill of Rights

This details your rights as a patient. Copy is posted in each office location.

HIPAA Privacy Notice

By signing below, you consent to the use and disclosure of your protected health information by The Orthotic and Prosthetic Centers, our staff, and our business associates for treatment, payment, and health care operations purposes. For a more detailed description of our uses and disclosures of protected health information, please review our Notice of Information Practices ("Notice"). You have the right to review our Notice prior to signing this consent. The terms of this Notice may change. If the terms do change, you may obtain a revised copy by contacting us at the above address or phone number and requesting a revised Notice. You have the right to request in writing, that we restrict our disclosures of your protected health information that we would otherwise be permitted to make for treatment, payment and health care operations, although we are not required to agree to these restrictions. However, if we agree to further restrictions, they are binding on us. Finally, you have the right to revoke the consent in writing, except to the extent that we have taken action in reliance on it. Copy is posted in each office location.

Medicare Supplier Standards

Outlines standards that are to be maintained by The Orthotic and Prosthetic Centers as a Medicare provider. Copy is posted in each office location.

Custom Devices

Custom devices are measured or cast to your body specifications. A lot of time and effort goes into making these devices. It is our company policy that all custom fabricated devices, once made, need to be delivered within six (6) weeks. As soon as the device is ready we will contact you for fitting and delivery. If you fail to respond within the allotted six (6) weeks, we will bill your insurance. However, we will hold your device for one (1) year and will be happy to have you come in for a fitting and delivery appointment to pick up your device during that time.

Consent to Treat

I hereby authorize The Orthotic and Prosthetic Centers to provide requested orthotic and/or prosthetic services.

Consent to Treat Minor Or Other Dependent

I, _____ hereby authorize and request the designated clinicians and/or designated assistants of The Orthotic and Prosthetic Centers to provide the needed orthotic and/or prosthetic services for

_____ (patient's name).

YES / NO Have you received a like or similar device within the last 5 years from either The Orthotic and Prosthetic Centers or any other provider?

YES / NO Are you currently residing in a nursing home?
Name of Home _____

YES / NO Are you currently receiving home health (VNA) or Hospice benefits?

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

I, the undersigned, have read and understand the policies and agreements above and hereby give my consent. I also attest that the above questions have been answered truthfully to the best of my knowledge.

_____ _____
Signature of Patient or Responsible Party Date

_____ _____
Print Name of Patient or Responsible Party Relationship