CAROLINA ORTHOTICS & PROSTHETICS

How did you hear about Carolina Orthotics & Prosthetics?____

Patient Name:____ Date of Birth:____________________

Social Security#:____ Sex:______________________

Mailing Address:____

City:____ State:________________ Zip:______________

Physical address if different:____

City:____ State:_________________ Zip:______________

Home phone:____________________ Work Phone:___________________ Cell Phone:________________

Email: (optional)____

Emergency Contact:____ Phone:_____________________

Primary Insurance:_____________________________________ ID#:_______________________________

Group#:_____________________ Primary cardholder & DOB:_____________________________________

Secondary Insurance:___________________________________ ID#:_______________________________

Group#:_____________________ Primary cardholder & DOB:_____________________________________

CLINICAL INFORMATION

Is your prescription related to an accident/injury? Yes No *If so, date of injury?_____________________

Are you currently "inpatient status" at any facility? Yes No Height:__________ Weight:__________

Referring Physician:_______________________ Primary Care Physician:____________________________

If you are diabetic, who is your treating physician?____

<u>*PLEASE CHECK ALL THAT APPLY*</u> Are you currently undergoing Physical Therapy? □Yes □No

□Allergic to Latex □Deep Vein Thrombosis □HIV/AIDS □Diabetes □Recent Surgery

□Osteoarthritis □Peripheral Neuropathy □MRSA □Cancer □Osteoporosis

□Cerebral Palsy □Peripheral Vascular Disease □Stroke □Post-Polio □Scoliosis

□Down Syndrome □Rheumatoid Arthritis □Muscular Dystrophy □Multiple Sclerosis

ASSIGNMENT OF BENEFITS, FINANCIAL RESPONSIBILITY, & ACKNOWLEDGMENT OF POLICIES

PLEASE CAREFULLY REVIEW EACH SECTION AND SIGN WHEN COMPLETED

ASSIGNMENT OF BENEFITS: I hereby authorize direct payment of Medicare, Medicaid, Veterans Medical Center, and/or private insurance benefits to be made directly to Carolina Orthotics & Prosthetics, LLC. (COP) on a continuing basis until revoked by me. I understand that I am responsible for sending to COP any and all payments that I receive directly from my insurance company in payment for treatment or services provided by COP.

FINANCIAL RESPONSIBILITY: I understand that COP will expect payment in full for any balances not covered by my insurance such as co-pays, deductibles, and/or non-covered items. COP will make known to me any estimated costs before an item can be ordered, fabricated or delivered. Any costs that will be my responsibility to pay are due to COP at the time of fit and delivery, and in some cases before ordering or fabrication of my device can be started. Iam also aware that I am responsible for notifying COP of any changes to my insurance information.

RELEASE OF INFORMATION: I authorize any holder of medical or other information about me, to release requested information to COP, their assignees or successors, for the purpose of my treatment at COP, and in order to determine benefits and file claims with my insurance plan. I also authorize COP to file my related insurance claims and to release any information to my insurance company in order to process those claims.

PHOTOGRAPHIC CONSENT: I do hereby acknowledge and consent to the policy of COP that all patients will be photographed/videotaped wearing the device that has been provided by COP. I do understand that the photographs will be incorporated into my medical record and may be used for insurance documentation, clinical training, and updating my physician.

PRIVACY PRACTICES, SUPPLIER STANDARDS, AND RETURN POLICY: I have had the Notice of Privacy Practices (HIPAA), Medicare DMEPOS Supplier Standards and the COP Return Policy made available to me in writing.

In regards to protecting my privacy, do we have permission to: (Please circle Yes or No for each item)

YES NO Leave a message at home, work, or on a cell phone regarding scheduling appointments? If yes, which?
___ home phone ___ work phone ___ cell phone

YES NO Leave a message at home, work, or on a cell phone regarding specific medical equipment information? If yes, which?
___ home phone ___ work phone ___ cell phone

YES NO Mail a letter to your home to notify you if we cannot reach you by phone?

YES NO **DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM COP MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHO?**

____
(Name & relationship to patient)

By signing below, I certify that I have read and understand all provisions above and have answered all questions truthfully. I am also stating that I choose Carolina Orthotics & Prosthetics, LLC. to provide my prosthetic/orthotic care. I am aware that there are other providers in the area and have chosen Carolina Orthotics & Prosthetics, LLC. without being persuaded or coerced.

Signature:____ Date:_____________________

*If you are completing these forms for the patient, please complete the section below:

Name (Please Print):____

Relationship to Patient:____

Who is financially responsible for the Patient (POA)?_____________________________________

Address:____

Home Phone:__________________ Work Phone:__________________ Cell Phone:_________________