For Office Use Only: Account #:_____

PATIENT INFORMATION (*Please Print All Information)* Date:_____

Last Name: _____ First Name: _____ MI:_____

Street Address: _____ Apt #:_____

City: _____ State: _____ Zip Code: _____

Phone # 1: Cell/Home/Work/Other _____ : (_____)_____

Phone # 2: Cell/Home/Work/Other _____ : (_____)_____

Birth Date: _____-_____-_____ Age: _____ Male: ☐ Female: ☐

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other ☐

Social Security #: _____ - _____ - _____ E-Mail Address: _____

Occupation: _____ Employer: _____

RESPONSIBLE PARTY *(if patient is a minor, please complete this section)* Self/Same as above: ☐

Last Name: _____ First Name: _____ MI: ____

Street Address: _____ Apt #:_____

City: _____ State: _____ Zip Code: _____

Phone # 1: Cell/Home/Work/Other _____ : (_____)_____

Phone # 2: Cell/Home/Work/Other _____ : (_____)_____

Birth Date: _____ Age: _____ Male: ☐ Female: ☐

Social Security #: _____ - _____ - _____ E-Mail Address: _____

Occupation: _____ Employer: _____

Relationship to Patient: _____

How did you first hear about Choice O&P? Doctor Referral ☐ Radio Ad ☐

Website ☐ Family / Friend ☐ Other ☐ _____

MEDICAL INFORMATION *(Please Complete this Section Fully)*

Referring Physician:_____ Phone #: _____

Primary Care Physician: _____ Phone #: _____

Diagnosis / Nature of Injury: _____

Were you injured in an automobile accident? YES ☐ NO ☐

Is your condition due to a work related injury? YES ☐ NO ☐

Have you had a brace or artificial limb in the past 5 years? YES ☐ NO ☐

Do you have a latex / neoprene allergy? YES ☐ NO ☐

Are you Diabetic? YES ☐ NO ☐

If Yes, please list diabetic treating physician: _____Phone #: _____

PROSTHETIC PATIENTS : Left ☐ Right ☐ Below Knee ☐ Above Knee ☐ Upper Extremity ☐

Date of Amputation: _____

INSURANCE INFORMATION *(Please complete this section & hand your card(s) to the receptionist.)*

Is your insurance plan an Affordable Care Act (Obamacare) plan? YES ☐ NO ☐

Policy Holder Name: SELF ☐ or OTHER _____

Policyholder Date of Birth: _____ Relationship to Patient: _____

SECONDARY INSURANCE INFORMATION

Policy Holder Name: SELF ☐ or OTHER _____

Policyholder Date of Birth: _____ Relationship to Patient: _____

WORKERS COMPENSATION / LIABILITY INSURANCE **MVA / LIABILITY CLAIMS – Please be advised that you are responsible for payment of all services; Payment cannot be withheld pending a settlement of your claim.*

Claim Number: _____ Date of Injury: ____-_____-_____Place of Injury: _____

Employer at Time of Injury: _____ Employer Phone #: _____

Claim Adjuster: _____ Phone #: _____

For Office Use Only: Pt Name: _____ DOB: _____

Choice Orthotics and Prosthetics, 314 Erin Drive, Suite 101, Knoxville, TN 37919, 865-588-4256

ACKNOWLEDGEMENT OF RECEIPT

I certify that I have received a copy of the Choice O&P Notice of Privacy Practices and Patient Bill of Rights, Medicare Supplier Standards, Warranty Information, Mission Statement and Patient Responsibilities contained in the patient brochure.

X _____ _____

Patient/Guardian Signature **Date**

RETURN POLICY

Federal Law PROHIBITS re-use of medical supplies and equipment. Therefore, Choice O&P cannot accept any prescribed items for return or refund except in cases of manufacturer defects.

PAYMENT AGREEMENT

I agree that in the event my insurance or other third party payor refuses to pay the rental or purchase price of the equipment or service, that I will be responsible for those payments. If for any reason my account should become delinquent, I agree to pay for all billing charges, interest charges, collection fees, and reasonable legal fees. Collection calls may be made to any phone number (including cell phone numbers) that you have provided to us.

RELEASE OF INFORMATION

I authorize any of my medical providers to release to Choice Orthotics & Prosthetics any information including protected health information (PHI) necessary for the purpose of preauthorizing or billing services or goods received at Choice O&P. I further authorize Choice Orthotics & Prosthetics to release medical records to my referring medical provider(s). I understand that this PHI will not be used for any other purposes other than outlined above and will be subject to all HIPPA rules and regulations concerning personal health information. I also understand this release is valid as long as I am under the care of the practitioners of Choice O&P unless revoked by written request.

X _____ _____

Patient/Guardian Signature **Date**

Consent for Healthcare Messages

I, _____, give permission to the practitioners and staff of Choice O&P to leave messages regarding my healthcare in the following manner when I am not available:

☐ May **ONLY** leave information with me in person – No Voice Mail Message will be left. (If this is checked, skip the next choices and complete the Contact Information below)

Please mark all that apply – (If the box above is checked, please leave these blank.)

☐ May leave estimated patient responsibility on my answering machine / voicemail.

☐ May leave general questions / information on my answering machine / voicemail.

If any are checked below, please list the name of the person we may give information to:

☐ May leave estimated patient responsibility with the person(s) listed below

☐ May leave general questions / information with the person(s) listed below

☐ I prefer that all healthcare messages be given to the person(s) listed below

Name of Person(s) Authorized	***Relationship***	***Phone***

May we contact you for marketing purposes? YES ☐ NO ☐

X _____ _____

Patient (or guardian) Signature Date