For Office Use Only: Account #:________________

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

Last Name: ________________________________ First Name: ______________________________ MI:_____

Street Address: ____ Apt #:_______City: ___________________________

State: ________ Zip Code: ____________**Primary Phone** #: 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:** ____

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: ___________ Birth Date: _____________ Age: ____

Phone # 1: Cell/Home/Work:(______)____________________ Phone # 2: (____)____________________________

Male: ☐Female: ☐ Social Security #: _________ - _______ - _________

E-Mail Address: ______________________________ Relationship to Patient: ___________________________________

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**

APPOINTMENTS

We schedule one patient at a time and your appointment is reserved just for you. If you are ten or more minutes late to your appointment, we may need to reschedule your appointment for another day.

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**

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

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 #: ______________________________

MEDICAL INFORMATION *(Please Complete this Section Fully)*

Referring Physician: _____________________________________ Phone #: ________________________________

Primary Care Physician: __________________________________ Phone #: ________________________________

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: ______________________

MEDICAL HISTORY Height: _____ft. _____in. Weight: ______lbs.

Are you currently residing in a nursing home/or are you going to be residing in a nursing facility within the next 30 days: Yes No If yes, Facility Name: _____________________________

Activity level: ____Low ____Medium ____High ____Highly active

How would you describe your general health? ____Poor ____Fair ____Good ____Excellent

Do you have any contact precautions or communicable disease our staff should be aware of: Yes No
(For example: MRSA, Staph, Strep A, etc.)? If yes, explain: ____

Attending Therapy? ____Physical ____Occupational ____Both

Therapist: ___________________________________ Phone: ________________________

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; or email in an encrypted format

☐ 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***

IN CASE OF EMERGENCY, CONTACT:______________________________ PHONE#(____)________________

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

X______________________________ ______________________

Patient (or guardian) Signature **Date**