PATIENT INFORMATION

Please Print

First: _____Middle: _____Last: _____

Street: _____City: _____ State: _____ Zip: _____

Home Phone: (___) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Email Address: _____ May we contact you by email? Yes _____ No _____

Social Security Number: _____ Date of Birth: _____ Sex: M _____ F _____

Emergency Contact: _____ Phone: (____) _____

Referring Physician or Facility: _____

Employer: _____

Employer Address: _____ Phone: (____) _____

Spouse Name: _____ Spouse Employer: _____

Spouse Employer Address: _____ Phone :(____) _____

Spouse Social Security Number: _____ Spouse Date of Birth: _____

**********<u>**Please present insurance card to receptionist**</u>**********

Primary Insurance	Secondary Insurance
Insurance Company: _____	Insurance Company: _____
Group #: _____ ID #: _____	Group #: _____ ID #: _____
Subscriber Name: _____	Subscriber Name: _____
Subscriber SSN: _____	Subscriber SSN: _____
Subscriber Date of Birth: _____	Subscriber Date of Birth: _____
Patients Relationship to Subscriber: _____	Patients Relationship to Subscriber: _____

**********Complete this section if injured at work (Workman's Compensation)**********

Date of Accident: _____ Company Responsible for Payment: _____

Company Address: _____Workman's Compensation Claim #: _____

Contact Person/Case Manager: _____ Phone: (____) _____

Notice of Privacy Practices (must be signed by all new patients)

By signing below, I acknowledge I have been provided information on American Prosthetics & Orthotics, Inc. Notice of Privacy Practices, as mandated by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

You may select individuals to whom we may release information on your care. If you choose to do so, please list their name below:

1. _____ 2. _____ 3._____

Signature_____ Date_____

(If patient is a minor or unable to sign, the Parent, Guardian or Attorney-in-Fact must sign above and complete the Responsible Party section below)

Release of Information to Insurers and Assignment of Benefits (must be signed by all new patients)

To the extent permitted by law, I consent to American Prosthetics & Orthotics, Inc. use and disclosure of my protected health information to carry out payment activities in connection with my insurance claim. This information will be used exclusively for the purpose of evaluating and administering claims for benefits. I agree to be responsible for all charges not paid by my insurance plan, unless prohibited by law, or unless American Prosthetics & Orthotics, Inc. has a contractual agreement with my plan prohibiting all or a portion of such charges. I further authorize and direct payment of benefits otherwise payable to me directly to American Prosthetics & Orthotics, Inc.

Signature: _____ Date: _____

(If patient is a minor or unable to sign, the Parent, Guardian or Attorney-in-Fact must sign and complete the Responsible Party section below)

Medicare Signature on File Agreement (must be signed by all Medicare beneficiaries.)

I request that payment of authorized Medicare benefits be made either to me or on my behalf to American Prosthetics & Orthotics, Inc. for any services furnished me. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature_____ Date _____

(If patient is unable to sign, Guardian or Attorney-in-Fact must sign above and complete the Responsible Party section below)

Emergency Contact:

Please sign below if we may get in touch with your emergency contact to verify your current contact information if we are unable to reach you.

Signature: _____ Date: _____

(If patient is unable to sign, Guardian or Attorney-in-Fact must sign above and complete the Responsible Party section below)

Responsible Party (If patient is under 18 or unable to sign)

First: _____ Middle: _____ Last: _____

Street: _____ City: _____ State: _____ Zip: _____

Home Phone: (____) _____Work Phone: (____) _____Cell Phone: (____) _____

Signature: _____Date: _____