Advanced Prosthetics, Inc.

Patient Name _____

(Last) (First) (M)

Address _____

(Street) (City) (State) (Zip)

Home Phone _____ Cell Phone _____

Emergency Contact _____ Phone Number _____

Date of Birth _____ SSN _____

Referring Physician _____ PCP _____

Diabetic ___ Yes ___ No If yes, physician who treats your diabetes _____

Email Address _____

How did you hear about Advanced Prosthetics? TV ____ Friend ____ Other _____

Insurance Information

Primary _____ ID# _____

Secondary _____ ID# _____

Name Of Insured _____ DOB _____ SSN _____

Workman's Compensation Insurance

Carrier _____ Date of Injury _____ Claim# _____

Contact Person _____ Phone Number _____

Acknowledgement of Receipt of Notice of Privacy Practices

I certify that I have received a copy of Advanced Prosthetics, Inc.'s Notice of Privacy Practices to review. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills, or in the performance of Advanced Prosthetics, Inc.'s health care operations. The Notice of Privacy Practices also describes my rights and Advanced Prosthetics, Inc.'s duties with respect to my protected health information. The Notice of Privacy Practices is posted at the main desk in the lobby area. Advanced Prosthetics, Inc. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment. I have been provided a copy of the Medicare Supplier Standards (if applicable).

Advanced Prosthetics, Inc.

Patient name and DOB:_____

FINANCIAL POLICY, AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS:

I understand that I am personally responsible for payment of bills to Advanced Prosthetics, Inc. at the time service is rendered. I hereby authorize 1) the release of medical information by my primary care and referring physicians, nursing facilities and/or outpatient facilities to Advanced Prosthetics, Inc. for the purpose of obtaining authorization for services to be rendered or for the payment of an insurance claim, 2) authorize release of medical information between Advanced Prosthetics, Inc., physicians, insurance company(s), nursing facilities, and/or outpatient facilities that may require to file an insurance claim or appeal the claim on my behalf. I also give authorization to my insurance company to pay Advanced Prosthetics, Inc. for services provided.

I hereby authorize future contact for care, from Advanced Prosthetics, follow up and continual treatment, in regards to the prosthetics and/or orthotics I have been provided. My plan of care allows for Advanced Prosthetics to continue this contact, at any future time, for the life and care of my prosthetic/orthotic.

_____

Signature of Patient (or person signing for patient)

_____

PRINTED Name of Patient (or person signing for patient)

_____

Date

_____

Description of Person Signing (mother, father, foster parent, grandparent, caregiver, POA, etc.)