
VA Patient Intake Paperwork

Patient Name: _____
(Last) (First) (M)

Address: _____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____

Email Address: _____

Emergency Contact/Relationship: _____ Phone Number: _____

****Height: _____ Weight: _____****

Referring Physician: **VA Referred**

How did you hear about Advanced Prosthetics? **VA Referral**

**Are you allergic to any materials such as latex, plaster, fiberglass, silicone, etc.? Yes ___ No___

If yes, please list/explain: _____

**Advanced Prosthetics, Inc.**

***Patient name and DOB:*** _____

**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).

Signature of Patient (or person signing for the patient) _____

PRINTED Name of Patient (or person signing for the patient) _____

Date_____

Relationship of Person Signing (mother, father, grandparent, caregiver, POA, etc.) _____

ADVANCED PROSTHETICS

*ACKNOWLEDGEMENT OF RETURN POLICY*

*RETURN POLICY:*

It is our goal to make sure you are satisfied with the products and services you receive here at Advanced Prosthetics. Please inspect the quality and fit of your product at the times services are rendered. If you do not feel your standards have been met, please notify the fitter or practitioner at the time of your visit. Once compression stockings or mastectomy supplies are worn out of the building they CANNOT be exchanged or returned for a refund. Custom items are not returnable. Custom foot orthotics/items require at least 50% of amount due (that is non-refundable) before we proceed with fabrication.

However, any mastectomy items that have not yet been worn, must be returned within 48 hours with tags and original packaging if there is a fitting issue. Diabetic shoes may be returned/exchanged within 10 days of the fitting appointment. Within the 10-day period, shoes must be in "like-new" condition with the manufacture provided inserts and original box before consideration is given for returns or exchanges.

If a product is defective, exchanges will be made based on the manufacturer's warranty. I have read, understand and agree to the terms listed above.

Patient's signature_____Date_____