

# Advanced Orthopedic Designs

## PATIENT INFORMATION

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security \_\_\_\_\_  
Home Address \_\_\_\_\_  
Street City State Zip Code  
Home Phone \_\_\_\_\_ Cell \_\_\_\_\_ Sex: ( ) M / ( ) F  
Marital Status: Single / Married / Divorced / Widowed E-Mail: \_\_\_\_\_  
How did you hear about us? Doctor Referral / PT Referral / Internet Search / YouTube / Friend / Other: \_\_\_\_\_

## PARENT/GUARDIAN INFORMATION

Parent/Legal Guardian Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Parent/Legal Guardian Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

## PHYSICIAN INFORMATION

Referring Physician: \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_  
Primary Physician: \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_  
Physical Therapist: \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

## INSURANCE INFORMATION

PRIMARY INSURANCE: \_\_\_\_\_ SECONDARY INSURANCE: \_\_\_\_\_  
ID #: \_\_\_\_\_ ID #: \_\_\_\_\_  
Subscriber's Name: \_\_\_\_\_ Subscriber's Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Relationship: \_\_\_\_\_

## WORKERS COMP

Is this injury work related: ( ) Yes / ( ) No Claim #: \_\_\_\_\_ Date of Injury: \_\_\_\_\_  
Insurance Company: \_\_\_\_\_ Adjuster: \_\_\_\_\_ Phone Number: \_\_\_\_\_

## EMERGENCY CONTACT

(If patient is a minor, emergency contact MUST be someone other than child's parent/legal guardian)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

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## MEDICAL HISTORY

\*Have you had any type of bracing before? ( ) Yes / ( ) No When? \_\_\_\_\_ What kind? \_\_\_\_\_

Do you reside in a Nursing Home? ( ) Yes / ( ) No Nursing Home Name/Number: \_\_\_\_\_

Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Shoe Size: Right \_\_\_\_\_ Left \_\_\_\_\_ Ambulatory? ( ) Yes / ( ) No

Underlying diagnosis? Cerebral Palsy / Spina Bifida / Brain Injury / Other: \_\_\_\_\_

Reason for Visit: \_\_\_\_\_

## PAYMENT POLICY

All services rendered are the financial responsibility of the patient/parent/guardian regardless of insurance coverage. We can, in no way, guarantee coverage. Benefits are determined by your insurance when your claim is processed. All benefit calculations are only estimates, based on information obtained from your insurance company. The actual final Patient Responsibility may be different than what was previously calculated.

1. Insurance assignments are accepted following verification of coverage for all contracted insurance companies. Deductibles and Co-insurances are due at the time of service unless a payment plan has been arranged.
2. Fifty percent (50 %) of the balance for non-covered custom-made devices is due at the time of cast and measurement, with the balance due at the time of delivery

## HIPAA RELEASE

I authorize Advanced Orthopedic Designs to furnish information for the purpose of treatment, payment or healthcare operations. My signature assigns benefits to Advanced Orthopedic Designs to bill insurance claims on my behalf for the duration of my treatment. I have been provided the opportunity to review the HIPAA and Notice of Privacy Practice. I agree that a representative of Advanced Orthopedic Designs may contact me at the phone numbers I have listed and I may also be contacted by mail in the form of a postcard or mail-out.

## SIGNATURE ON FILE AUTHORIZATION

I authorize use of my signature on this form for all my insurance submissions.

I authorize release of information to Advanced Orthopedic Designs and from Advanced Orthopedic Designs in order to facilitate insurance reimbursement.

I understand that I am personally responsible for my bill and agree to pay any portion of the bill that is not covered by Insurance.

I authorize payment to be made directly to Advanced Orthopedic Designs.

I permit a copy of this authorization to be used in place of original.

Signature of Patient/Guardian \_\_\_\_\_ Date \_\_\_\_\_

Name of Parent/Guardian (if applicable, please print) \_\_\_\_\_

Updated Signature \_\_\_\_\_ Date \_\_\_\_\_

Updated Signature \_\_\_\_\_ Date \_\_\_\_\_

Updated Signature \_\_\_\_\_ Date \_\_\_\_\_