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: _____

ID #: _____

Subscriber's Name: _____

Date of Birth: _____ Relationship: _____

SECONDARY INSURANCE: _____

ID #: _____

Subscriber's Name: _____

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 _____