PATIENT INFORMATION FORM

Patient Name ________________________ **Date of Birth** ____________ **Social Security** ____________

Home Address ________________________ **City** ____________________ **Zip** __________

Home Phone ______________ **Cell** ______________ **Work** ______________ **Other** ______________

Circle one choice for each of the following: **Preferred number of contact**

Ok to call work? **Sex** **Marital Status**

How did you hear about us? **If other, please explain:** ______________________________

PARENT/GUARDIAN INFORMATION

Mother's Name: ______________________ **SSN:** ________________ **DOB:** ____________

Employer: ______________________________ **Employer Phone:** ________________

Father's Name: ______________________ **SSN:** ________________ **DOB:** ____________

Employer: ______________________________ **Employer Phone:** ________________

PHYSICIAN INFORMATION

Referring Physician ______________________ **Phone** ______________ **Fax** ____________

Primary Physician ______________________ **Phone** ______________ **Fax** ____________

Physical Therapist ______________________ **Phone** ______________ **Fax** ____________

INSURANCE INFORMATION

PRIMARY INSURANCE: ______________________________ **Phone:** ________________

ID Number ______________________ **Group Number** ______________________

Policy Holder: **Name** ______________________________ **Date of Birth** ____________

Relationship to patient: ______________________________

SECONDARY INSURANCE: ______________________________ **Phone:** ________________

ID Number ______________________ **Group Number** ______________________

Policy Holder: **Name** ______________________________ **Date of Birth** ____________

Relationship to patient: ______________________________

EMERGENCY CONTACT

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

Emergency Contact: ______________________ ______________ ____________

Name **Relationship** **Phone Number**

If you are a **Medicare** patient please fill out the following questionnaire.

Have you been provided with any type of bracing in the past 5 years? ____ YES ____ NO If yes, what kind of brace____________

Diabetic? ______ YES ______NO Have you received a pair of diabetic shoes or inserts this year? ______ YES ______ NO

Phys. Treating Diabetes ____ Phone: _______________________________

Does pt reside in a nursing home? _____ YES ____ NO Nursing home name: ___________________________________

Nursing home Phone #: _________________________________

If you are a **Workers Comp** patient please fill out the following questionnaire.

Insurance Carrier ____________________________ Claim # ________________________ Date of Injury_______________

Employer (AT TIME OF INFURY) _______________________ Employer Contact __________________ Phone_______________

Employer Address________________________________ City____________________ ST________ Zip_______________

Adjuster ____ Phone ________________________________

PAYMENT POLICY

All services rendered are the financial responsibility of the patient's parent or guardian regardless of insurance coverage.

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 later payment plan has been arranged by administration. *** If it is later determined that the patient is not eligible at the time of service or the item is non-covered due to a specific policy exclusion, the balance will become the responsibility of the patient/ parent/ guardian.
2. Medicare does not cover all items. For covered items, Medicare covers 80% and has a yearly $140.00 deductible.
3. Workers Comp, Medicaid and all state funded programs require authorization before services are rendered. Private insurance is always primary to Medicaid and state funded programs.
4. Non-Covered items (such as non diabetic shoes and inserts) and special order items require a partial payment at the time of the order. Extra freight charges for rush deliveries are the patient's responsibility.
5. Please make sure the item fits properly and comfortably at the time of service. We will adjust the item at no charge for the lifetime of the device. If for some reason you are dissatisfied with the device you have received, you may return it for a full refund to you and your insurance company.

HIPPA RELEASE

I here by authorize Advanced Orthopedic Designs to furnish information to any State or Federal agency, insurance carrier, or physician for the purpose of treatment, payment or healthcare operations. My signature assigns benefits to Advanced Orthopedic Designs to bill legitimate insurance and/or Medicare claims on my behalf for the duration of my treatment.

I have been provided the opportunity to review the HIPPA 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.

MEDICAL RELEASE

I permit a copy of these authorizations and assignments to be used in place of this original, which is on file at the provider's office. I authorize any practitioner examining and/or treating me to release to any third party (such as insurance company or governmental agency) any medical information and records concerning diagnosis and treatment when requested for use in determining a claim(s) for payment.

I hereby certify that the above information is correct and current to my knowledge, and that I will notify Advanced Orthopedic Designs of any changes that may occur.

I have read and understand the Payment Policy, HIPPA Release, and Medical Release

Signature of Patient/Guardian ____ **Date** ________________

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

Updated Signature ____ Date _____________

Updated Signature ____ Date _____________

Updated Signature ____ Date _____________