PROSTHETIC & ORTHOTIC CARE, INC
REGISTRATION FORM

(Please Print)

Today's date:	Referring Physician:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Reason for visit today:

Is this Visit Work Comp related? ❑ Yes ❑ No	Claim # Work comp Company:	Case Manager Name: Contact Phone #:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance ❑ Medicare ❑ BCBS ❑ GHP/Coventry ❑ UHC ❑ Medicaid ❑ Aetna ❑ Healthlink ❑ Tricare ❑ VA ❑ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to P&O Care. I understand that I am financially responsible for any balance. I also understand that telephone inquiries to my insurance are not a guarantee of coverage or benefits, and I may owe and additional amount after insurance review. I also authorize Prosthetic & Orthotic care, Inc to release any information required to process my claims.

Patient/Guardian signature *Date*

Prosthetic & Orthotic Care Inc.

Please read and Initial Each of the following statements

_____**Statement to Permit Payment of Medicare/ Insurance Benefits to Provider, Physicians and Patient**

I request that Payment of authorized Medicare Benefits be made to either me or on my behalf for any services furnished to me, by or in **Prosthetic and Orthotic Care, Inc**. including physician services. I authorize any holder of medical or other information about me to be released to the **Centers for Medicare and Medicaid Services** and its agents as needed to determine these benefits for related services.

_____ **CMS Standards**

I certify that I have received a copy of the current CMS Medicare DMEPOS Supplier Standards.

_____ **Acknowledgment of Receipt of Notice of Privacy Practices**

I certify that have received a copy of the ***Prosthetic and Orthotic Care's Notice of Privacy Practices***. The notice describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of bill or in the acquisition of required documentation needed for authorization purposes. The ***Privacy Practices*** also describes my rights and Prosthetic and Orthotic cares duties with respect to my protected health information. The notice is posted in the reception rea of the office. Prosthetic and Orthotic care reserves the right to change the Privacy Practice that is described in the ***Notice of Privacy Practices***. I may obtain a revised copy by calling the office and having it mailed to me or given to me in person at my next appointment.

_____ **Photo/ Video Release**

I give my consent for Prosthetic and Orthotic Care, Inc. to take my photographs/video of and prosthetic/ orthotic device that I receive along with the affected limb(s) for my personal file and insurance purposes.

_____ **Signature Attestation**

I certify that the Signature and name below were provided by me and is true representation of my legal signature as acknowledged by Medicare/Medicaid. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____**Grievances/Recommendations**

I Certify that I am aware that I have the right to feely voice grievances or recommend changes in my care without fear of reprisal or interruption of service. I am aware that any service or product complaints made will be followed up on by the Clinical Operations Manager within 48 Hours, and billing complaints will be followed up on by the Office Administrator within 48 hours.

Patient Name (Please print): _____

Patient Signature: _____

Date: _____

Medicare ID #_____