PATIENT INFORMATION
Allen Orthotics & Prosthetics, Inc.

Patient's Name: _____ SS #: _____-_____-_____
First Name MI Last Name

Date of Birth: _____ □ Male □ Female □ Single □ Married

Street Address: _____

City/State/Zip code: _____

Mailing Address *if different*: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Work Phone: (_____) _____ Preferred contact #: □ Home □ Cell □ Work

Spouse's Name: _____ Phone #: _____

PATIENT WHO IS A MINOR OR HAS A GUARDIAN

Person responsible for scheduling and billing: □ Guardian □ Other: _____

Responsible Party: _____ Relationship: □ Parent □ Guardian □ Other: _____

Responsible Party's Drivers License #: _____

Responsible Party's SS #: _____-_____-_____

Responsible Party's Date of Birth: _____

Responsible Party's Address/City/State/Zip code:_____

Responsible Party's Home Phone: (_____) _____

Responsible Party's Employer: _____ Work Phone: (_____) _____

Responsible Party's Employer Address/City/State/Zip code: _____

Medical Power of Attorney: □ No □ Yes If yes, please provide a copy

MEDICAL INFORMATION

In case of emergency, contact (not living with you): _____

Phone Number: (_____) _____Relationship to Patient: _____

Is your medical condition due to an injury? □ No □ Yes If yes, what is the date of the injury?_____

If yes, is the injury covered under: □ Auto accident □ On the job injury □ Other liability insurance_____

Do you currently reside in a skilled nursing facility? □ No □ Yes, Where? _____

If you are a Veteran, do you plan on using your VA benefits to obtain services? □ Yes □ No

Referring Physician's Name: _____

Primary Physician's Name: _____

Therapist Name: _____ Location of Therapist:_____

Do you have allergies to any contact materials? □ No □Yes, please describe: _____

Other Diagnosed Medical Conditions:

□ Vascular Disease	□ Stroke	□ Pacemaker	□ Tuberculosis
□ Heart Disease	□ Pain	□ Seizures	□ ADD/ADHD
□ Diabetes	□ Dementia/Alzheimer's	□ Cerebral Palsy	□ Psychological
□ Hepatitis/HIV	□ Osteoporosis	□ COPD	□ Dermatological
□ Arthritis	□ Chronic Pain	□ Other _____	

CONSENT FOR TREATMENT, AUTHORIZATION TO RELEASE INFORMATION, ACKNOWLEDGEMENT OF BILLING, WARRANTY AND RETURN POLICIES

I authorize treatment from Allen Orthotics & Prosthetics to perform appropriate assessment and approve the treatment procedures recommended by the treating practitioner/s.

I authorize the release of any medical or other information to Allen Orthotics & Prosthetics necessary to facilitate the care including, but not limited to, medical advice, treatment history, clinical records, diagnosis and/or prognosis.

I authorize the release of any medical or other information from Allen Orthotics & Prosthetics necessary to facilitate the care including, but not limited to, medical advice, treatment history, clinical records, diagnosis and/or prognosis.

I acknowledge my understanding of the General Billing, Warranty and Return Policies.

I certify that the information provided by me is true, accurate and complete.

X _____ _____

Patient / Responsible Party's Signature **Date**

If patient is a Minor, we must have Responsible Party Signature

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HIPAA NOTICE AND ACKNOWLEDGEMENT

I acknowledge that I have had the opportunity to review and/or obtain a copy of the facility's Notice of Privacy Practices.

X_____ _____

Patient / Responsible Party's Signature **Date**

_____

Relationship to Patient

CMS SUPPLIER STANDARDS FOR MEDICARE BENEFICIARIES

The products and/or services provided to you by Allen Orthotics & Prosthetics, Inc are subject to the supplier standards contained in the Federal regulations shown at 42 Code of Federal Regulations Section 424.57(c). These standards concern business professional and operational matters (e.g. honoring warranties and hours of operation). The full text of these standards can be obtained at http://ecfr.gpoaccess.gov. Upon request we will furnish you a written copy of the standards.

The NSC statement can be found here: http://www.palmettogba.com/palmetto/providers.nsf

I acknowledge that I am a Medicare beneficiary and have been given an opportunity to obtain and review a copy of the Supplier Standards.

X_____ _____

Signature of Beneficiary **Date**

INTERNAL USE ONLY

Intake received/reviewed by: _____

PRIVATE INSURANCE

If the private insurance policy holder is someone other than the patient or the responsible party as listed on the first page, please complete this page thoroughly. Otherwise, please indicate which insurance is primary, secondary and tertiary and make certain Allen Orthotics & Prosthetics has copies of your cards.

Primary Insurance Company: _____

Policy holder's Name: _____ Policy/ID #:_____

SSN #:_____-_____-_____ Date of Birth: _____

Insured's Address/City/State/Zip code: _____

Employer Name: _____ Employer #: (_____) _____

Insured's Relationship to Patient: □ Spouse □ Parent □ Guardian Other: _____

Secondary Insurance Company: _____

Policy holder's Name: _____ Policy/ID #:_____

SSN #:_____-_____-_____ Date of Birth: _____

Insured's Address/City/State/Zip code: _____

Employer Name: _____ Employer #: (_____) _____

Insured's Relationship to Patient: □ Spouse □ Parent □ Guardian Other: _____

MEDICARE

Please answer the following only if you use Medicare benefits

1. Have you ever received the same or similar supplies/services?□ Yes □ No

If yes, list the equipment / supplies: _____

When was it purchased? _____ Who was it purchased from? _____

Was the item returned to the original supplier? □ No □ Yes, Why? _____

Is the item being replaced? □ Yes □ No

Is there a new medical necessity? □ Yes □ No

2. May we contact you by telephone concerning Medicare covered items and services? □ Yes □ No

ASSIGNMENT OF BENEFITS

I request that payment of authorized Medicare, Medicaid or Private Insurance benefits be made either to me or on my behalf for any services furnished to me by Allen Orthotics & Prosthetics, Inc. I authorize any holder of medical or other information about me to release to the Centers for Medicare & Medicaid Services and its agents or to the appropriate Private Insurance company any information needed to determine these benefits or benefits for related services.

x_____ _____

Signature of Beneficiary or Designee **Date**

_____

Relationship to beneficiary if designee

INTERNAL USE ONLY
Intake received/reviewed by: _____

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WORKER'S COMPENSATION

Please answer the following only if you are filing for Worker's Compensation coverage

If you were injured on the job, the following information is required:

Date of injury: _____ Claim #: _____

How did this injury happen: _____

State the accident occurred in:_____

Name of Employer when injury occurred: _____

Employer Contact Name: _____

Employer Address/City/State/Zip code: _____

Employer Phone #: (_____) _____

Worker's Compensation Insurance Company: _____

Phone #: _____

Address/City/State/Zip-code: _____

Adjuster's Name: _____ Phone #: (_____) _____

Case Manager's Name: _____ Phone #: (_____) _____

INTERNAL USE ONLY

Intake received/reviewed by: _____