Allen Orthotics & Prosthetics, Inc.

PATIENT INFORMATION

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: _____

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

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

Responsible Party's Date of Birth: _____

Responsible Party's Drivers License #: _____

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

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

Responsible Party's Home Phone: (_____) _____

MEDICAL INFORMATION

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

Phone Number: (_____) _____ Relationship to Patient: _____

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

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

Referring Physician's Name: _____

Primary Care Physician's Name: _____

Therapist's Name: _____ Location of Therapist:_____

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

Other Diagnosed Medical Conditions:

□ Tuberculosis	□ Stroke	□ Vascular Disease	□ Osteoarthritis
□ MRSA	□ Psychological	□ Heart Disease	□ Chronic Pain
□ Hepatitis	□ PTSD	□ COPD	□ Osteoporosis
□ HIV	□ Seizures	□ Pacemaker	□ Rheumatoid Arthritis
□ Diabetes	□ Alzheimer's/Dementia	□ Cerebral Palsy	□ Dermatalogical

□ Other _____

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

Please Initial

_____ 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**

_____

Relationship to Patient

---

24 HOUR CANCELLATION & NO SHOW FEE POLICY

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care.

Therefore, Allen Orthotics & Prosthetics reserves the right to charge a fee of $40.00 for all missed appointments ("no show") and appointments which, absent a compelling reason, are not cancelled with a 24 hour advance notice. "No Show" fees will be billed to the patient, their guardian, or other responsible party. This fee is not covered by insurance, and must be paid prior to your next appointment. Multiple "no shows" may result in termination from our practice.

Thank you for your understanding and cooperation as we strive to best serve the needs of our patients. By signing below, you acknowledge that you have received this notice and understand this policy.

X _____ _____

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

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

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

INTERNAL USE ONLY

Rev. 2020 **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 and secondary and make certain Allen Orthotics & Prosthetics has copies of your cards.

Allen Orthotics & Prosthetics does not bill third party insurances. Please ask if you have any questions regarding the insurance you plan to use for the services you were prescribed. Below, please indicate if the injury is covered under:

□ Auto Accident □ School Insurance □ Worker's Compensation
□ Other Liability Insurance_____

Primary Insurance Company: _____

Policy holder's Name: _____

Policy/ID #:_____

Group#_____

Date of Birth: _____

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

Insured's Relationship to Patient: □ Self □ Spouse □ Parent □ Guardian

□ Other: _____

Secondary Insurance Company: _____

Policy holder's Name: _____

Policy/ID #:_____

Date of Birth: _____

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

Insured's Relationship to Patient: □ Self □ Spouse □ Parent □ Guardian

□ Other: _____

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: _____

MEDICARE or MEDICARE ADVANTAGE INSURANCE

If the 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 and secondary and make certain Allen Orthotics & Prosthetics has copies of your cards.

Primary Insurance Company: _____

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

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 #: _____

Date of Birth: _____

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

Employer Name: _____ Employer #: (_____) _____

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

1. Do you currently reside in a skilled nursing facility? □ No □ Yes, Where? _____
2. 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
3. May we contact you by telephone concerning Medicare covered items and services? □ Yes □ No

CMS SUPPLIER STANDARDS FOR MEDICARE BENEFICIARIES
ASSIGNMENT OF BENEFITS

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

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.gov. Upon request we will furnish you a written copy of the standards.

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: _____

WORKER'S COMPENSATION

If you were injured on the job and <u>are filing for Worker's Compensation coverage,</u> the following information is required:

Date of injury: _____ State the accident occurred in: _____

Claim #: _____

SS #: _____-_____-_____

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

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

Worker's Compensation Insurance Company: _____

Phone #: (_____) _____

How did this injury happen: _____

Name of Employer when injury occurred: _____

Employer Contact Name: _____

Employer Street Address: _____

City/State/Zip code: _____

Employer Phone #: (_____) _____

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

X _____ _____

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

INTERNAL USE ONLY

Intake received/reviewed by: _____

Rev. 2020

Allen Orthotics & Prosthetics, Inc.

VETERAN'S INFORMATION

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

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

Mailing Address *if different than the VA has on file*: _____

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

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

Phone: (_____) _____ Relationship To You: _____

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

Other Diagnosed Medical Conditions:

□ Tuberculosis	□ Stroke	□ Vascular Disease	□ Osteoarthritis
□ MRSA	□ Psychological	□ Heart Disease	□ Chronic Pain
□ Hepatitis	□ PTSD	□ COPD	□ Osteoporosis
□ HIV	□ Seizures	□ Pacemaker	□ Rheumatoid Arthritis
□ Diabetes	□ Alzheimer's/Dementia	□ Cerebral Palsy	□ Dermatalogical

□ 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 and 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**

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**

INTERNAL USE ONLY

Intake received/reviewed by: _____

Rev. 2020