PATIENT INFORMATION

Name (Last, First, Middle Initial) _____ Sex

_____

Address

_____

City _____ State _____ Zip _____ E-mail Address

_____

Home Phone _____ Work Phone _____ Cell Phone

_____

Social Security#_____ Date of Birth _____ Age _____ Height _____ Weight

_____

Does patient live at the above address 6 months of the year? _____ yes _____ no

Does patient live in a Nursing Home or Health Care Facility? _____ yes _____ no

Have you ever worn a brace or prosthesis previously? _____ yes _____ no

If yes, where did you get brace or prosthesis? _____

Prescribing Physician Full Name _____ Tel

#_____

Diabetic Physician Full Name_____ Tel

#_____

Listed below are names of <u>people who can have **access to my personal health information**</u>.

1. _____ _____
   name their relationship to me
2. _____ _____
   name their relationship to me
3. _____ _____
   name their relationship to me

_____ I want Central Brace & Prosthetics, Inc. to contact me concerning my financial responsibility ***<u>before</u>*** ordering supplies or starting any work on my orthosis/prosthesis.

_____ I want Central Brace & Prosthetics, Inc. to start fabrication of my orthosis/prosthesis immediately. I agree to pay Central Brace & Prosthetics, Inc. any co-pay and/or deductible as determined by my insurance plan.

_____ I am aware I am responsible for full payment of services and a deposit is required on all custom orders before any work is started. Central Brace & Prosthetics, Inc. will assist me in filing insurance for my reimbursement.

Benefits, Medical Information Release Authorization and Acknowledgment of Financial Responsibility

I request my insurance benefits, if any, be paid directly to the provider. I authorize the release of any information necessary to provide services of process claims. As the responsible party I understand that I am personally responsible for the entire amount of my claim or any portion of the service completed if the service is canceled by me or my representative and that insurance benefits may be limited or non-existent. I agree to notify Central Brace & Prosthetics, Inc. immediately of any change in insurance coverage or status.

<u>RESPONSIBLE PARTY</u> **(*if different from patient*)** (Last Name, First) _____

Address

_____

Signature **of Responsible Party** _____ Date _____

YES, I have received a copy of the **HIPPA Notice of Privacy Practices and/or Medicare Standards** for Central Brace & Prosthetics, Inc. _____ (*patient initials*)

CENTRAL BRACE & PROSTHETICS, INC.

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