CONFIDENTIAL PERSONAL RECORD

Patient:_____ **Phone:**_____
Last First M.I.

Address:_____ **Cell:**_____
Street City State ZIP

Email:_____ **DOB:**_____ **SSN:**_____

Sex: ☐ M ☐ F **Ethnicity:**_____ **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐_____

Emergency Contact:_____ **Phone:**_____
Name Relationship

PHYSICIAN*
**Required*

Primary Care Physician:_____ **Phone:**_____

Prescribing Physician:_____ **Phone:**_____

Diabetic Physician:_____ **Phone:**_____

INSURANCE*
**Required*

Primary Ins:_____ **Phone:**_____

Secondary Ins:_____ **Phone:**_____

FACILITY

Are you currently a resident of a nursing facility? ☐ Yes ☐ No

If Yes, Facility:_____ **Phone:**_____

BWC or WORK INJURY

Is this an industrial injury? ☐ **Yes** ☐ **No** **Claim #**_____ **Date of Injury:**_____

If Yes, Employer:_____ **Phone:**_____

Address:_____

PARENT/ GUARDIAN

Is patient a minor? ☐ **Yes** ☐ **No**

If Yes, Parent/Legal Guardian:_____ **Phone:**_____

Address (if different than above):_____

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I certify this information is true and correct to the best of my knowledge. I will notify **American Orthopedics, Inc.** of any changes in my insurance status or the above information. I understand, in case of default, I will be responsible for all fees associated with the collection of this account.

I understand that **American Orthopedics, Inc.** will fill the prescription from my physician as written. Other than slight modifications for comfort, they will not alter the basic prescription without direct orders from the physician. The professional staff at **American Orthopedics, Inc.** is comprised of licensed Orthotists and Prosthetists. As such, they provide, but do not prescribe, orthotic and prosthetic care.

X_____ _____
Patient's Signature (Parent/Legal Guardian Signature if patient is a minor) *Date*

PATIENT MEDICAL HISTORY

Patient:_____
Last *First* *M.I.*

☐ **There have been NO CHANGES to my Medical History SINCE MY LAST VISIT. (Sign below & Continue to PAGE 3 ►)**

Medical Complications (check all that apply):

☐ Diabetes ☐ Arthritis ☐ Serious Visual Impairment

☐ Heart Disease ☐ Mental Disease ☐ Obesity

☐ Ulcers, callusing ☐ Edema ☐ Other (specify):_____

Have you had any previous surgeries related to your present condition(s)? ☐ Yes ☐ No If Yes, please describe:

_____

_____

Are you currently wearing an orthosis? ☐ Yes ☐ No If Yes, please describe:

_____

_____

AMPUTATION INFO (if applicable)

Site of Amputation: ☐ Above left knee ☐ Above right knee ☐ Below left knee ☐ Below right knee

☐ Other:_____

Surgeon:_____ **Facility:**_____ **Date of Amputation:**_____

Date Previous Prosthesis Provided:_____ **Company Providing Prosthesis:**_____

I certify this information is true and correct to the best of my knowledge. I will notify **American Orthopedics, Inc.** of any changes to the above information.

X _____ _____

Patient's Signature (Parent/Legal Guardian Signature if patient is a minor) *Date*

PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

I, _____, understand that as part of my healthcare, **American Orthopedics, Inc.** originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals

I have been given a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this Consent
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that **American Orthopedics, Inc.** is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this Consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that **American Orthopedics, Inc.** reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should **American Orthopedics, Inc.** change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, e-mail).

I wish to have the following restrictions to the use or disclosure of my health information:_____

I wish to be contacted in the following manner:

Home Phone	OK to leave ☐ message ☐ call-back number ONLY
Cell Phone	OK to leave ☐ message ☐ call-back number ONLY
Work Phone	OK to leave message at (_____) _____
Email	OK to email to _____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax and/or other electronic transmission.

I understand and accept the terms of this Consent.

X _____ _____

Patient's Signature (Parent/Legal Guardian Signature if patient is a minor) *Date*

FINANCIAL ARRANGEMENTS AND MEDICAL INSURANCE

PAYMENT FOR SERVICES IS DUE AT THE TIME SERVICES ARE RENDERED unless payment arrangements have been approved in advance by our financial manager. We accept cash, checks, and major credit cards.

The invoice you receive at your visit provides all the information you will need to file a claim for reimbursement from your insurance company. We will be happy to assist you in processing your insurance forms for reimbursement. Any such request must be accompanied by a completed insurance form for each visit.

In some cases, we will file your insurance claims for you. However, **you are responsible for all co-payments and deductibles.**

***** WE CANNOT ACCEPT ASSIGNMENT FOR CLAIMS OF LESS THAN $100.00 *****

***** A FEE OF $25.00 WILL BE ASSESSED FOR EACH RETURNED CHECK *****

Our fees for service are generally considered to fall within the acceptable range by most companies and therefore are covered up to the maximum allowable determined by each carrier.

This applies only to companies who pay a percentage (such as 50% or 80%) of "UCR". UCR is defined as "Usual, Customary and Reasonable" fee for this region. Thus, our fees are considered usual, customary and reasonable by most insurance companies. This statement does not apply to companies who reimburse based on an arbitrary "Schedule" of fees, which bears no relationship to the current standard and cost of care in this area. **NOT ALL SERVICES WE PROVIDE ARE COVERED BENEFITS**. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that, as medical care providers, **our relationship is with <u>you</u>**, not your insurance company. As a service to you, our office will submit claims to your insurance company. However, you are ultimately responsible for the account. If temporary financial problems arise that may affect timely payment of your account, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us for assistance.

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered.

X _____ _____

Patient's Signature (Parent/Legal Guardian Signature if patient is a minor) *Date*

AUTHORIZATION TO DISCLOSE INFORMATION

Regarding Patient:_____ **DOB:**_____

Requesting from Facility:_____

Please read the entire form before signing below.

The purpose of this signed authorization is to help determine eligibility for benefits, including looking at the combined effect of any impairments that by themselves would not meet your insurance company's definition of eligibility for coverage and payment. **American Orthopedics, Inc.** may need to secure medical documentation from one or more of your physicians in order to provide your insurance company with the specific details they require in order to process your claim more quickly and accurately.

I, _____, voluntarily authorize and request disclosure of all my medical records, including written, oral and electronic, or other information related to my ability to perform tasks pursuant to my PROSTHETIC and/or ORTHOTIC TREATMENT and CARE with **American Orthopedics, Inc., 1151 West 5th Avenue, Columbus, Ohio 43212**. This includes specific permission to release:

1. All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s), including but not limited to:
   - Progress notes
   - Information relating to and including prescriptions
   - Hospital notes

2. Information about how my impairment(s) affects my ability to complete tasks and activities of daily living and affect my ability to work and enjoy life.

3. Information created within twelve (12) months after the date this authorization is signed, as well as past information.

Please sign using blue or black ink only.
Individual authorizing disclosure:

X _____ _____
Patient's Signature *Date*

X _____ ☐ Parent ☐ Guardian ☐ Power of Attorney
Authorized Signer

X _____ _____
Witness (if needed) *Date*

Address:_____
Street *City* *State* *ZIP* *County*

Medicare patients only CONTINUE TO PAGE 6 ►

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER, PHYSICIAN(S) AND PATIENT

PROSTHETIC & ORTHOTIC SERVICES

Regarding Patient:_____ **DOB:**_____

I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I require that payment of authorized benefits be made on my behalf. I assign the benefits payable for covered Medicare services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

I request that payment under the medical insurance program be made to **American Orthopedics, Inc., 1151 West 5th Avenue, Columbus, Ohio 43212** on any bills for services furnished to me by this company.

X _____ _____

Patient's Signature *Date*

_____

Health Insurance Claim Number