National Prosthetics and Orthotics, Inc.

Professional Services Quality Braces and Limbs

NAME:_____ DATE OF BIRTH:_____

PHONE#: _____ ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

SS#:_____ Email: _____

Referring M.D.:_____ Family M.D. Name _____

Ref. M.D. Phone #_____ Family M.D. Phone#_____

Ref. M.D. NPI #_____ Family M.D.NPI #_____

EMPLOYMENT INFORMATION

NAME OF EMPLOYER:_____

ADDRESS:_____

PHONE#_____

RESPONSIBLE PARTY

NAME:_____ PH#_____

RELATION TO PATIENT:_____

ALTERNATE CONTACT:_____ PH#_____

Medical History – Check any illness you have had:

- ☐ Diabetes
- ☐ Hepatitis
- ☐ Ulcers
- ☐ Syphilis
- ☐ HIV
- ☐ Rheumatic Fever
- ☐ Substance Abuse
- ☐ Bleeding Tendency
- ☐ Heart Trouble
- ☐ Vein Trouble
- ☐ Kidney Disease
- ☐ Cancer
- ☐ Gonorrhea
- ☐ High Blood Pressure
- ☐ Tuberculosis

TODAY'S DATE:_____

SIGNATURE:_____

The Products and / or services provided to you by National Prosthetics and Orthotics, 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.

Acknowledgment of Receipt of Notice of Privacy Practices

I certify that I have received a copy of **National Prosthetics and Orthotics** Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills, or in the performance of **National Prosthetics and Orthotics** health care operations. The Notice of Privacy Practices also describes my rights and **National Prosthetics and Orthotics** duties with respect to my protected health information. The Notice of Privacy Practices is posted in the waiting area.

National Prosthetics and Orthotics reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, or by asking for one at the time of my next appointment.

Signature of Patient or Personal Representative _____

Printed Name of Patient or Personal Representative _____

Date: _____

Description of Personal Representative's Authority (Relationship)

The following individuals may have access to my PHI:

☐ Spouse ☐ Child/Children ☐ Parent(s)/Guardian(s) ☐ Other

Name(s): _____

Initials: _____

☐ I refuse to sign this form.

Signature of Patient or Personal Representative_____

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TO THE PATIENT

You are responsible for payment of this account and will continue to receive a statement until the account is paid in full. We will verify and bill your insurance carrier for you. If there is a problem with insurance coverage for your services, you will be notified.

HOSPITAL SERVICES

If you received our services in the hospital, you are directly responsible to us for payment of that service. Our charges are not applied to your hospital bill.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize **National Prosthetics and Orthotics, Inc.** to furnish information to insurance carriers concerning my illness and treatment and hereby assign **National Prosthetics and Orthotics, Inc.** all payments for medical services rendered. I understand that I am responsible for all charges, including those not paid by insurance.

When full payment of your account is made at the time of service, we will instruct your insurance carrier to send payments directly to you.

Thank you.

DATE: _____

SIGNED: _____

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