Orthopedic Appliance Company, Inc.

OFFICE USE ONLY

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The following information is necessary in order to properly bill your insurance company.

Section 1: PATIENT INFORMATION

First Name:_____ **MI:**_____ **Last Name:**_____

Address:_____ **Employer:**_____

City:_____ **State:**_____ **Zip:**_____

Home Phone:_____ **Work Phone:**_____ **Cell Phone:**_____

Birth Date:_____ **Social Security #**_____ **Sex:** Male / Female

Referred By Doctor:_____ **Diagnosis:**_____

Email: _____ **Height:** _____ **Weight:** _____

If Accident, Specify Date and Description:_____

Currently in assisted living / skilled nursing facility? Y / N **Facility Name:**_____

Section 2: PRIMARY CARD HOLDER'S INFORMATION (If Different From Above)

First Name:_____ **MI:**_____ **Last Name:**_____

Home Phone:_____ **Work Phone:**_____ **Birth Date:**_____

Social Security #_____ **Relationship to Patient:** _____

**PLEASE REVIEW/COMPLETE NEXT PAGE-→
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Deductible Total: _____ **Total Met:** _____

Coinsurance _____

NOTES:

_____

_____

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Orthopedic Appliance Company, Inc.

75 Victoria Road, Asheville, NC 28801 • Phone: 828-254-6305 • Fax: 828-254-6110

Acknowledgement of Receipt of Notice of Privacy Practices

I certify that I have received a copy of 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 bills or in the performance of Orthopedic Appliance Company, Inc.'s health care operations. The Notice of Privacy Practices also describes my rights and Orthopedic Appliance Company, Inc.'s duties with respect to my protected health information. The Notice of Privacy Practices is posted in the front lobby of Orthopedic Appliance Company, Inc. and on Orthopedic Appliance Company, Inc.'s website at www.OrthopedicApplianceCo.com.

Orthopedic Appliance Company, Inc. 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, asking for one at the time of my next appointment, or accessing Orthopedic Appliance Company, Inc.'s website.

Assignment of Benefits

The customer requests that payment of authorized insurance benefits are made on the customer's behalf to Orthopedic Appliance Company, Inc. for any services furnished. The customer understands that the signature requests the payment by the insurance carrier be made directly to Orthopedic Appliance Company, Inc..

Medical Information Release Authorization

The customer authorizes any holder of medical information about the customer to be released to their insurance carrier or its agents any information needed to determine benefits or the benefits payable for related services. The customer understands that the below signature(s) authorizes release of medical information necessary to pay the claim.

Financial Responsibility Consent

The undersigned agrees to assume financial responsibility for any claim or portion of claim thereof, due Orthopedic Appliance Company, Inc. for services provided, not covered by the insurance policy as of the date listed below. If the insurance company denies coverage for a product, the undersigned will assume financial responsibility for its payment. The undersigned acknowledges the responsibility for any payment not received from the insurance carrier within thirty (30) days from the date of service.

_____

Signature of Patient or Personal Representative

_____

Printed Name of Patient or Personal Representative

_____

Date

_____

Description of Personal Representative's Authority