Orthopedic Appliance Company

PATIENT INFORMATION

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

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

Date of Birth: _____ **Gender:** _____ **Email:** _____

Marital Status: _____ **Language:** _____ **Referred by Doctor:** _____

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

Address: _____

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

Height: _____ **Weight:** _____ **Diabetic:** YES or NO **Diabetic Doctor:** _____

If Accident, Specify Date and Description: _____

Currently in Assisted Living/Skilled Nursing Facility? YES or NO **Facility Name:** _____

PRIMARY CARD HOLDER'S INFORMATION (If Different from Above)

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

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

Date of Birth: _____ **Gender:** _____ **Relationship to Patient:** _____

Orthopedic Appliance Company

Asheville • Fletcher • Hickory • Bryant, AR
Phone: 828-254-6305 • Fax: 828-254-6110

Acknowledgement of Receipt of Notice of Privacy Practices

You have the right to read our Notice of Privacy Practices before you decide to sign this Consent. Our Notice provides a description of our treatment, payment activities, healthcare operations, the uses and the disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you to read it carefully and completely before signing this consent. 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. A revised Notice of Privacy Practices can be obtained 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.
By signing this form you consent for Orthopedic Appliance Company, Inc. to use and disclose your protected health information to carry out treatment, payment activities and healthcare operations.

Acknowledgement of Receipt of CMS Supplier Standards

The products and/or services provided to you by Orthopedic Appliance Company, 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 https://www.ecfr.gov/. Upon request we will furnish you a written copy of the standards.

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.

_____ _____

Printed Name of Patient Patient Date of Birth

_____ _____

Signature of Patient or Personal Representative Date

_____

Printed Name of Personal Representative

_____

Description of Personal Representative's Authority