Welcome to: Spears Prosthetics & Orthotics

PATIENT INFORMATION SHEET

Patient Information (All Information is confidential and will not be given out)

Name:_____Sex:_____D.O.B._____

Address_____City_____St_____Zip:_____

Home Phone ( )_____ Cell Phone: ( )_____

Emergency Contact:_____Phone#_____ Relationship_____

Social Security #_____ HT:_____ WT:_____

What is your shoes size?_____

Marital Status: Single:_____Married:_____Divorced:_____ Widow:_____

Email Address_____

Have you ever had any type of brace before? Yes_____ No_____ (If yes please tell

us what type_____ When?_____

WORK INFORMATION:

Employer Name:_____

Employer Address:_____

Work Number:_____

Work Email Address:_____

INSURANCE INFORMATION:

Primary Insurance_____

Policy Id#_____

Policy Holders Name_____ D.O.B_____

Secondary Insurnace_____

Policy Holders Name_____ D.O.B. _____

Policy ID #_____

WORKERS COMPENSATION:

Is your condition the result of an injury? Yes_____No_____Date of Injury_____

Was your injury work related? Yes_____No_____Claim#_____

Name of adjuster:_____Phone#_____

Physician Information:

Name of the Physician that referred you Dr._____Phone#_____

When is the last time you seen your doctor?_____

Are you a diabetic? Yes_____No_____ If so, Who is your diabetic doctor that suplies your insulin or Pill? Dr. _____Phone#_____

HEALTH INFORMATION:

Please check by indicating any of the following you have experienced:

_____Heart Surgery/attack/disease_____Stroke/Paralysis____Bleeding disorder____Kidney Disease
_____Insulin dependent diabetic_____Balance problems_____Cancer_____Liver Disease
_____Non-Insulin dependent diabetic_____Osteomyelitis_____Arthritis_____Depression_____Anxity
_____Lung/Respiratory Problems_____Pain_____HIV/AIDS_____Staph or other infections____PVD
_____Poor Circulation_____Sores/Open Wounds_____Hepatitis A,B,C,_____Vision Problems
_____High or Low Blood Pressure_____Blood Clots_____Seizure Disorder_____Hearing Impaired

If you checked any of these conditions above or are experiencing others, Please indicate the specific nature below.
_____
_____

Please list any allergies that you have (especially to latex, creams, dyes, or other materials):
_____
_____

Please list any surgeries below:_____Date_____Surgeon_____
_____Date:_____Surgeon_____

The undersigned certifies that the above information is true, accurate and complete:

Print Name of Patient_____

Signature of Patient/Guarantor:_____DATE_____

Other than the Patient list who can speak with Spears Prosthetics & Orthotics in regards to your account.

1. _____ Relationship:_____

2. _____ Relationship:_____

Revised 06/02/23

FOR PROFESSIONAL SERVICES PROVIDED BY SPEARS PROSTHETICS AND ORTHOTICS LLC.

CONSENT TO TREATMENT: This is to certify that I, or my Authorized Legal Representative, do hereby consent and authorize Spears P&O, administration and performance of all evaluativeand/or Prosthetics, Orthotics, or Pedorthic (O&P) practitioner may be considered necessary or advisable as a course of my treatment.

RELEASE OF INFORMATION: I authorize Spears P&O and /or their assigns to disclose any or all information in the medical record to any person, corporation, or agency which is/may be liable fo all or part of the charges, or who may be responsible for determining the necessity, appropriateness, amount, or other matter related to fees charged, including my insurance company, its representative an HMO,PPO, Workers Compensation carrier, welfare funds, Medicare and/or Medicaid programs and/or their intermediaries or carriers. I further authorize Spears P&O to disclose such information to its insurance carriers as may be necessary. All my past and present medical records will be made available to any duly authorized person acting in any capacity on be half of Spears P&O.

ASSIGNMENT OF INSURANCE BENEFITS: I authorize and request payment be made directly to Spears P&O for the purpose of my treatment in this or any other facility or location. I understand that insurance claims are filed as a courtesy, but I am solely and financially responsible for charges, fees, and/or orther debts incurred by me for treatment and that I will aid Spears P&O in their attempt to collect payment for devices provided to me.

COVERED OR NON-COVERED CHARGES: I understand that some devices may or may not be covered by my health insurance, and that some parts of the devices may be covered, and other parts of the same device not covered as my health insurance approves/applies coverage benefits. However, I agree and understand that I am ultimately financially responsible for all charges, where "covered" or "not-covered" by my health insurance benefit plan, I agree to pay Spears P&O for all collection fees, court cost, and other expenses involved in collecting any charges hereunder.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THIS DOCUMENT, IS THE PATIENT, OR IS DULY AUTHORIZED BY THE PATIENT, TO EXECUTE THIS AGREEMENT AND ACCCEPTS IT'S TERMS THEREOF, AND HAS RECEIVED A COPY OF THIS DOCUMENT.

_____

PATIENT SIGNATURE

_____

DATE

CONDITIONS OF TREATMENT

PRESCRIBED SERVICES ONLY: Spears P&O provides devices only by physician referral and will only provide devices based upon a fully executed prescription by a licensed physician.

WARRANTY CONDITIONS: Spears P&O warrants that the physician's prescription and Spears P&O 's professional good-faith interpretation of that prescription will be strictly followed in providing this P&O device. Warranty is provided in good faith only for fit and fuction as prescribed for a period of 90 days. Warranty for fit and function is void if any changes or alterations to the devices are performed by anyone other than by an employee/authorized agent of

Acknowledgement of Receipt of Notice of Privacy Practices

SPEARS PROSTHETICS AND ORTHOTICS

I certify that I have received a copy of **Spears 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 **Spears Prosthetics and Orthotics** health care operations. The Notice of Privacy Practices also describes my rights and **Spears Prosthetics and Orthotics** duties with respect to my protected health information. The Notice of Privacy Practices is posted in front office lobby.

Spears 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 asking for one at the time of my next appointment.

_____

Signature of Patient or Personal Representative

_____

Print Name of Patient or Personal Representative

_____

Date

_____

Description of Personal Representative's Authority

Spears P&O. Normal wear and tear and/or repairs, as determined by a member of Spears P &O professional staff, may not be covered by this warranty. No guarantee has been made or implied to me/the patient as to the effectiveness, success or failure of the prescribed devices. No one is authorized to abridge or amend this document other than the Presedent of Spears P&O. Further, I agree to hold harmless, defend and indemnify Spears P&O against any and all liability, loss, or expense whatsoever resulting from negligent or improper use of the devices provided.

PATIENT'S CERTIFICATION AUTHORIZATION: I certify, understand, and agree by my signature below, or by the signature of my Authorized Representative, that I am responsible for any health insurance deductible and co-insurance amounts. I permit a copy of this authorization to be valid as the original.

RIGHT TO CHOOSE: I understand that it is my right to choose the provider of my O&P devices and I choose Spears P&O as my provider of choice.

FOR MEDICARE BENEFICIARIES: Medicare regulations require that a supplier must meet certain defined standards in order to provide services to Medicare beneficiaries. These Supplier standards will be provided to you. Your signature, or the signature of your Authorized Representative indicates receipt of the patient's copy of the document, a copy of the Medicare Supplier Standards, or Spears P&O Medicare Beneficiary Complaint Resolution Protocol. Signature below grants permission to Spears P&O to contact you by telephone concerning your Medicare-covered devices.

_____ _____

Patient Signature **DATE**

OR

_____ _____

Authorized Legal Representative & Relationship to patient **DATE**