

Student Information form- for School Packet

Student Name: _____ Date of Birth: _____

Street Address: _____ City: _____ ZIP: _____

Phone: _____ Email: _____ Height: _____ Weight: _____

INSURANCE:

PLEASE TEXT PICTURE of ID and Both Sides of Insurance card to 770-800-2030

First Insurance Name: _____ ID#: _____

Is this through Georgia Medicaid ? YES NO **IF NO Please answer the following questions:

Primary Insurance Company: _____

Name of person who pays for the insurance: _____

Relation to student: _____ DOB: ____/____/____ SSN: ____/____/____

Employer: _____ Phone: _____

Do you Also have Medicaid? YES NO If Yes: ID#: _____

RELEASE OF INFORMATION I authorize any of my medical providers to release to Merciful O&P any information including protected health information (PHI) necessary for the purpose of preauthorizing or billing services or goods received at Merciful O&P. I further authorize Merciful O&P to release medical records to my referring medical provider(s). I understand that this PHI will not be used for any other purposes other than outlined above and will be subject to all HIPPA rules and regulations concerning personal health information. I also understand this release is valid as long as I am under the care of the practitioners of Merciful O&P unless revoked by written request.

PAYMENT AGREEMENT I agree that in the event my insurance or other third-party payor refuses to pay the purchase price of the equipment or service, that I will be responsible for those payments. If for any reason my account should become delinquent, I agree to pay for all billing charges, interest charges, collection fees, and reasonable legal fees. Collection calls may be made to any phone number (including cell phone numbers) that you have provided to us. I give permission for Merciful O&P to contact me by mail, phone, or voice mail message, to schedule, re-schedule, or remind me of appointments or to inform me of any insurance carrier information pertinent to my service or products being rendered.

Photo/Video

By signing, you consent to the use of photos or videos of yourself or your child for treatment purposes. If used for educational, promotional, or marketing purposes further consent will be requested. Your privacy and confidentiality will always be respected.

I hereby authorize Merciful O&P and its licensed clinicians to evaluate, measure, and provide orthotic treatment as deemed appropriate for my student's condition. I understand that this may include the fabrication, fitting, and adjustment of custom or prefabricated orthotic devices. I acknowledge that: I have the right to ask questions and receive information about my treatment, treatment will only proceed with my full understanding and voluntary consent and I may withdraw this consent at any time.

Acknowledgement of Receipt:

I certify that I have received a copy of Merciful O&P's Notice of Privacy Practices, Medicare Supplier Standards, Warranty Information, Mission Statement and Patients Bill of rights/Patient Responsibilities contained on www.mercifuloandp.com

Patient/Gaurdian Signature: _____ Relation _____ Date: _____