NEW LIFE
Prosthetics and Orthotics

PATIENT INFORMATION

PLEASE PRINT: Date _____

Patient's name _____
Last *First* *MI*

Address _____
Street # *City, State* *Zip code*

Phone numbers (cell) _____ (business) _____ (home) _____

Email _____ Date of birth _____ Marital status _____

Referring physician _____ Diagnosis _____

Primary care / Family physician _____
Name *Address* *Phone*

Employer _____
Name *Address* *Phone*

Emergency contact _____
Name and relationship *Address* *Phone*

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If minor, name of parent / guardian _____

Address _____
Street # *City, State* *Zip code*

Phone numbers (home) _____ (business) _____ (cell) _____

Employer _____
Name *Address* *Phone*

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Source of payment (check one): Self ___ Private Insurance ___ Medicare ___
Worker's Compensation ___ Medical Assistance ___ Other ___

Primary Insurance Company (if applicable) _____

Address _____

ID# _____ Group # _____

Policy holder's name _____ relationship to insured _____ date of birth _____

Secondary Insurance Company (if applicable) _____

Address _____

ID# _____ Group # _____

Policy holder's name _____ relationship to insured _____ date of birth _____

Worker's Compensation (if applicable) Social Security # _____

Employer _____
Name *Address* *Phone*

Insurance Company _____
Name *Address* *Phone*

Claim # _____ Date of accident _____

Description of accident _____

Name of adjuster _____ Adjuster's phone number _____

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Please complete page 2, also.

Medical condition and/or any allergies? Please explain:

_____

_____

_____

_____

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Have you received an orthotic and/or prosthetic device within the past 5 years for the condition for which you are being treated today? If yes, please explain:

_____

_____

_____

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I have received, or been given access to, a copy of New Life Prosthetics and Orthotics' (NLPO) Notice of Privacy Practices. The Notice of Privacy Practices describes the uses and disclosures of my protected health information that may occur in my treatment, payment of my bills or in the performance of NLPO's health care operations. The Notice of Privacy Practices also describes my rights and NLPO's duties with respect to my protected health information. NLPO reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

_____
initials

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If I am a Medicare patient, I have received, or been given access to, a copy of Medicare Standards for DMEPOS Suppliers.

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initials

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I have received, or been given access to, the phone numbers for Center for Medicare & Medicaid Services, Board of Certification, and Texas Department of Licensing & Regulation.

_____
initials

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As a courtesy to you, we will file your claim with the approved insurance provider. By signing the assignment of benefits' line below, you authorize the insurance provider to send benefits to New Life Prosthetics and Orthotics. Also, by signing below, you agree that regardless of your insurance status, you are ultimately responsible for the balance of your account for services rendered. You also certify that the information provided on this form is true and correct to the best of your knowledge, and you will inform our office of any future changes.

_____

Insured's signature / Assignment of benefits ***Date***

Thank you for choosing New Life Prosthetics and Orthotics. We look forward to serving you.