PATIENT REGISTRATION FORM

Legal Name of Patient: _____ Gender: (M) (F) Marital Status: ___M ___D ___S___W

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ SSN: _____

Date of Birth: _____ Email Address: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Affected Body Part: _____ Diagnosis: _____ Date: _____

Who referred you to our office: _____ Phone: _____

Primary Care Physician: _____ Phone:_____

HEALTH INSURANCE INFORMTION

Primary Insurance Co: _____ Policy ID#: _____

Policy Holder Name: _____ DOB: _____ Relationship: _____

Secondary Insurance Co: _____ Policy ID#: _____

Policy Holder Name: _____ DOB: _____ Relationship: _____

WORKER'S COMP OR AUTO ACCIDENT ONLY: Workman's Comp _____ Auto Accident _____

Name of Employer/Company: _____ Phone: _____

Claim #: _____ Address: _____

Adjuster Name: _____ Date of Injury_____

ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITY/ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND RECEIPT OF MEDICARE SUPPLIER STANDARDS

I hereby assign to Valley Prosthetic and Orthotics Inc. (VPO) any and all rights to receive insurance benefits otherwise payable to me for products or services provided by VPO. I understand that my signature requests that payment by my insurance carrier be made directly to VPO. I authorize VPO to appeal denied insurance authorization and/or benefits on my behalf. For Medicare patients: I hereby understand that VPO has made available Medicare Supplier Standards. In the event, that my insurance carrier does not accept an assignment of benefits, I understand that all correspondence and payments to VPO may be sent directly to me, and that when such payments are received, I will hold them in trust to VPO for payment of my bill. I agree to assume financial responsibility for any claim or portion of claim thereof, due to VPO for supplies and services not covered by my insurance policy, as of the date of service. If my insurance company denies coverage for all or any product billed, or if my insurance coverage changes and payment is denied, I will assume financial responsibility for payment. In Medicare assigned cases, VPO agrees to accept the charge determination of the Medicare carrier as the full charge. I am responsible for the deductible, co-insurance, and non-covered services and denied payment. I understand that VPO has a legal obligation to seek payment from me for coinsurance amounts owed and that this agreement supersedes and will prevail over any other agreement to the contrary. I acknowledge that I have been provided a Notice of Privacy Practices. I give permission to VPO to obtain my medical records from my health care physicians/facilities. I give permission for VPO to take any photos/videos during my appointment to be added to my clinical file for my medical records.

_____ ** **I will provide VPO with any changes to my medical insurance coverage. If I fail to provide this information, I am liable for the entire amount of the device(s) provided****

I understand, acknowledge and agree to the terms set forth above. All above information is correct and complete.

Patient/Guardian Signature: _____ Date: _____