PRO rthotics & OT, LLC

Patient Registration Form

Today's Date: _____

Patient Information

Name: _____ Birthdate: _____

Mailing Address: _____

City:_____State_____ZIP Code _____

Parents Cell Phone: _____ (I give permission for PR Orthotics & OT to call this number and provide information regarding my child's appointments or care.) ☐ YES ☐ NO

Parent's Email Address: _____

Preferred method of contact: ☐ home phone ☐ cell phone ☐ e-mail

Pediatrician's Name and Number: _____

Referring practitioner's Name and Number: _____

Parent/Guardian Information

Name: _____

Mailing Address: (if different than above)_____

_____

Employer: _____ Occupation: _____

Preferred Language: _____

Primary Medical Insurance (Please provide insurance card to be photocopied.)

Ins. Co. Name: _____ Policy Holder Name: _____

Policy Holder Date of Birth: _____ Patient's relationship to policy holder: _____

Policy ID Number: _____ Group Number: _____

Secondary Medical Insurance (Please provide insurance card to be photocopied.)

Ins. Co. Name: _____ Policy Holder Name: _____

Policy Holder Date of Birth: _____ Patient's relationship to policy holder: _____

Policy ID Number: _____ Group Number: _____

I certify that I have read and agree to PR Orthotics & OT, LLC's (PRO) payment policy. I am eligible for the insurance indicated on this form and I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to PRO all money to which I am entitled for medical expenses related to the services performed, but not to exceed my indebtedness to PRO. I authorize PRO to release any medical information to my insurance carrier or third party payer to facilitate processing my insurance claims. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency. A $30.00 returned check fee will be charged for checks returned due to insufficient funds. I choose to receive communications from PRO by text or e-mail at the number or address stated above, including but not limited to communications about appointments, treatment, and payment. I understand that such e-mails and texts may not be secure and there is a risk that they may be read by a third party.

MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to PRO. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services. By signing, I confirm that have been provided with the DMEPOS thirty supplier standards to read.

I have reviewed a copy of PR Orthotics & OT, LLC's:

- ☐ **Privacy Notice**
- ☐ **Late or Missed Appointment Policy**
- ☐ **Patient Rights & Responsibilities**

Signature of Responsible Party : _____

Printed Name: _____ **Date:** _____