Patient Information

Patient Name _____ Date of Birth _____

Gender ___*M* ___*F* SSN _____ Email address _____

Height _____ Weight _____

Employer _____ Employer Phone _____

Phone (Home) _____ (Mobile) _____

Address _____

City _____ State _____ Zip _____

Responsible Party (*if under 18*) _____ Relationship _ Parent _POA

Emergency Contact /Relationship_____ Phone _____

Insurance

Primary _____ Policy # _____

Secondary _____ Policy # _____

Physician Information

Prescribing Physician _____ City/Phone _____

Primary Physician _____ City/Phone _____

Diagnosis (reason for visit)_____ Side ____*Left* ____*Right*

Are you diabetic? _____ Allergies? ___ Latex ___ Other _____

How did you hear of us? ___Facebook ___Doctor ___Physical Therapy ___Friend/Family

___Insurance ___ Pharmacy ___ Google ___ Other _____

I authorize the release of any medical information necessary to process claims or payment of medical charges and the use of this form on all insurance submissions. I also authorize Orthotic & Prosthetic Designs to act as my agent in obtaining payment from my insurance carrier and payment of any medical charges to Orthotic & Prosthetic Designs for services rendered.

I understand that all services rendered are on a payment for service basis and that I am responsible for my bill, including any deductible and co-payment. If collection becomes necessary, the undersigned shall pay all costs including certified letters, collection agency, and attorney fees. I permit a copy of this authorization to be used in place of the original. In signing this form, I verify receipt of services.

I certify that I have received or was offered a copy of Orthotic & Prosthetic Designs' Notice of Privacy Practices.

I certify that I have received or was offered a copy of the Medicare Standards for DMEPOS Suppliers (Medicare participants only).

I certify that I have received or was offered a copy of OPD's Warranty.

Notice of Privacy Practices, Medicare Standards and Warranty found on following pages.

Responsible Party Signature _____ Date _____