ORTHOTICS & PROSTHETICS
OF PINEHURST

95 Aviemore Dr
Pinehurst, NC 28374
t (910) 295-4489
f (910) 215-8035

Today's Date: _____/_____/______

Patient Information:
Name: ____

DOB: _____/_____/________ Sex: M☐ F ☐ SSN: ______-____-_______ Email: ________________@_____________

Vocational Status: Retired☐ Employed F/T☐ Employed P/T ☐ Unemployed☐ Student☐ DL#: ____________________
Marital Status: Married☐ Single☐ Separated☐ Spouse Name: ____
Divorced☐ Widowed☐ Spouse DOB: _______/_______/_______
Primary Language: ___________ For languages other than English, do you need an interpreter? _____
Home Phone: ______-______-__________ Work Phone: ______-______-__________ Mobile Phone: ______-______-__________
Physical Address: _______________________________________ Mailing Address: __________________________________
City: ___________________State: ______Zip:________ City: ___________________State: ______Zip:________
Employer Name: _______________________________________ Phone: ______-______-__________
Spouse's Employer Name: _______________________________________ Phone: ______-______-__________
Emergency Contact: Name: ____ Relationship: ________________________________
Home Phone #: ________-________-___________ Cell/Other Phone #: ________-________-___________
Insurance Information: PLEASE provide our office with a copy of your insurance card(s)/information. Check ALL that apply.
Medicare☐ Medicare Advantage Plan ☐____________________ Worker's Comp ☐__________________
Medicaid☐ TriCare☐ SSN of subscriber: _____-___-______ Blue Cross/Blue Shield ☐
Other ☐_____________________________________
If the Insured for PRIMARY coverage is someone other than the patient please identify here: Spouse ☐ Parent ☐
Primary Insured's Name: ____ DOB: ______/_____/_____
If the Insured for SECONDARY coverage is someone other than the patient please identify here: Spouse ☐ Parent ☐
Secondary Insured's Name: ____ DOB: _____/_____/_____
Medicaid Recipients ONLY:
If you have Medicaid coverage, who is listed as your Carolina Access Physician: ____________________________
County of issuance: _______________________

Physician Information:
Primary Care Physician: ____
Diabetic Care Physician: ______________________________________
Medical History:
Briefly describe the reason for your visit: ____
Is your visit due to an accident? Yes ☐ No ☐ If YES, what type? Auto ☐ Employment ☐ Other ☐ Date of Accident: ____/____/____
Have you had any surgeries related to this visit? Yes ☐ No ☐ If YES, when? ____/____/____
Have you been diagnosed with diabetes? Yes ☐ No ☐ If YES, date of diagnosis ____/____/____
Heart Problems ☐ Hepatitis C ☐ Hepatitis A or B ☐ Hypertension ☐ Alzheimer's Disease ☐ HIV Positive ☐ Psychiatric Problems ☐ Vascular Disease ☐ Arthritis ☐ Alcoholism ☐
Stroke ☐ Obesity ☐ Pacemaker ☐ Seizure Disorder ☐ Kidney Disease ☐ Pulmonary Disease ☐ Hearing Loss ☐
Osteoporosis ☐ MRSA ☐ Vision Problems ☐ Currently Pregnant ☐ Parkinson Disease ☐
Have you had an orthotic/prosthetic device within the past 5 years? Yes ☐ No ☐ If yes, approximately when? _____/_____/_____

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Insurance Assignment & Payment Policy (Conditions of contract(s) by and between O&P of Pinehurst and an insurance carrier may override office policies.)

Our office is pleased to accept insurance assignment for covered items only. As soon as coverage can be verified by the insurance carrier and the item(s) is/are delivered, our office will file the claim thereby assisting the patient with getting the claim paid.

Insurance should forward payment within 45 days of a claim being filed. If the insurance carrier takes longer than 60 days to pay, the patient/responsible party may be asked to make payment in full.

Our office cannot guarantee payment by any insurance carrier. We will make every attempt, at the beginning of service, to obtain verification of the policy coverage for services prescribed/requested and/or authorization if necessary.

In the event an insurance carrier reimburses the patient instead of O&P of Pinehurst for services rendered, the remaining balance becomes the patient's or responsible party's responsibility.

Any special financial arrangements must be made between the patient/responsible party and a qualifying representative of O&P of Pinehurst. All agreements must be signed by both parties.

Any costs associated with collection of payment from the patient is at the expense of the patient.

By signing below the patient/legally responsible person:

A. Certifies that he/she is authorized to furnish the requested information. Patient/legally responsible person understands that responsibility of payment lies with the patient/legally responsible person, not the insurance carrier.

B. Is in agreement with all stated policies here within.

C. Authorizes O&P of Pinehurst to file insurance claims on his/her behalf and accept assignment of benefits when applicable.

D. Authorizes the release of any information to the payer necessary to facilitate payment.

E. Permits a copy of this authorization to be used in place of the original and request payment of insurance benefits be made to the party accepting assignment of benefits.

F. Acknowledgement of receipt of the Notice of Privacy Practices; and

G. Acknowledge an understanding that the products and/or services provided to you by Orthotics & Prosthetics of Pinehurst are subject to the supplier standards contained in the Federal regulations shown at 42 Code of Federal Regulations Section 424.57(c). These standards concern business professional and operational matters (e.g. honoring warranties and hours of operation). The full text of these standards can be obtained at http://ecfr.gpoaccess.gov. Upon request, we will furnish you a written copy of the standards.

If patient is under 18 years of age, this form must be signed by a legally responsible adult who will be financially responsible.

Signature: ____ Date: _____/_____/________

Signed by someone other than patient? Yes ☐ No ☐ If Yes, identify relationship? ___________________________

Witness: ____

*Witnessing signature does not establish financial responsibility.