ORTHOTICS & PROSTHETICS OF PINEHURST: PATIENT INFORMATION

Last Name	Middle Initial:
First Name	Last 4 of SS# XXX-XX-_____
Address	
City , State, Zip	
E-MAIL	
Phone #	Home: Cellular:
Date of Birth	____/____/_____ POLICY HOLDER DOB IF DIFFERENT FROM PATIENT ____/____/_____
Insurance #	Primary Secondary
PHYSICIAN INFORMATION	PRIMARY PHYSICIAN:_____PHONE:_____ REFERRING PHYSICIAN:_____PHONE:_____
MEDICAL HISTORY	☐ Heart Problems ☐ Hepatitis C ☐ Alzheimers ☐ Hypertension ☐ HIV positive ☐ Psychiatric ☐ Vascular Disease ☐ Rheumatoid Arthritis ☐ Alcoholism ☐ Stroke ☐ Obesity ☐ Pacemaker/Defib ☐ Diabetes ☐ Osteoarthritis ☐ Seizure Disorder ☐ Kidney Disease ☐ Pulmonary Disease (TB) ☐ Hearinng Loss ☐ Osteoporosis ☐ Vision Problems ☐ Pregnant (current) ☐ Hepatitis A or B ☐ Parkinsons Disease ☐ MRSA Height:_____Foot _____ Inches Weight:_____ Lbs. Amputations: ☐ Yes ☐ No Reason/Cause:_____ ☐ Right ☐ Left ☐ Bilateral ☐ Upper Ext. ☐ Lower ☐ Above Knee ☐ Below Knee ☐ Above Elbow ☐ Below Elbow ☐ Toes ☐ Partial Foot

HIPAA	• **Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, and the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you to read it carefully and completely before signing this Consent. • **Purpose of Consent:** By signing this form, you consent for Orthotics & Prosthetics of Pinehurst to use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations
COMMUNICATION AUTHORIZATION	I authorize Orthotics & Prosthetics of Pinehurst to leave messages on my home phone, cell phone, or contact me by e-mail.
MEDICARE SUPPLIER STANDARDS	"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 athttp://ecfr.gpoaccess.gov. Upon request we will furnish you a written copy of the standards."
ASSIGNMENT OF BENEFITS	I authorize my insurance company to pay benefits directly to Orthotics & Prosthetics of Pinehurst. I understand my insurance company may not pay for services that are not a covered benefit or are not considered medically necessary. I also understand that there may be benefit limitations with no-fault carriers as deductibles and benefit maximums may apply. I agree to be financially responsible for all services provided by Orthotics & Prosthetics of Pinehurst.
SIGNATURE	I HAVE READ, UNDERSTOOD, AND HEREBY AGREE TO ALL OF THE TERMS STATED ABOVE. _____ _____ PATIENT OR AUTHORIZED REPRESENTATIVE SIGNATURE: DATE: