Patient Information

Patient Name _____ DOB _____

Social Security Number _____ Email _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Widowed

Spouse Name_____ SS#_____ DOB_____

Primary Insurance_____ ID#_____

Secondary Insurance_____ ID#_____

Employer _____ Phone _____

Emergency Contact _____ Phone _____

Relationship _____

Physician Name _____ Phone _____

Who referred you? _____

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 AMPUTEE PROSTHETIC CLINIC to use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Communication Authorization

I authorize AMPUTEE PROSTHETIC CLINIC to leave messages OR TEXT on my home phone, cell phone, or contact me by e-mail.

Medicare Supplier Standards

"The products and/or services provided to you by AMPUTEE PROSTHETIC CLINIC 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."

Assignment of Benefits

I authorize my insurance company to pay benefits directly to AMPUTEE PROSTHETIC CLINIC. 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 AMPUTEE PROSTHETIC CLINIC.

I have read, understood, and hereby agree to all of the terms stated above.*

Signature _____ Date _____