Prosthetic & Orthotic Solutions, LLC.

Assignment of Benefits, Consent to Release Information, & HIPAA Acknowledgement

Patient's Name (please print)	Patients Date of Birth	MRN# (office use)

I request that payment of authorized Medicare, Medicaid, or private insurance benefits be made to Prosthetic & Orthotic Solutions, LLC for any covered services furnished by Prosthetic & Orthotic Solutions, LLC. I agree to pay to Prosthetic and Orthotic Solutions, LLC the deductible and/or coinsurance on my claim. I understand and agree that I am responsible for the following expenses; any service my insurance plan deems "non-covered", all coinsurance and/or co-payment amounts, all deductibles, any amount that exceeds benefit limits under my insurance plan and any amount my insurance plan deems not covered because I was not insured on the date of service. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents, Champus/TRICARE and its agents, or any private insurance company any information needed to determine these benefits or the benefits payable for related services.

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 Prosthetic & Orthotic Solutions, LLC. to use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations
Medicare Supplier Standards	The products and/or services provided to you by Prosthetic & Orthotic Solutions, LLC. 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 Prosthetic & Orthotic Solutions, LLC. 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 Prosthetic & Orthotic Solutions, LLC.
Communication	I authorize Prosthetic & Orthotic Solutions, LLC. to leave messages on my home phone, and cell phone. I further authorize Prosthetic & Orthotic Solutions to contact me by mail or email.

I have read, understood, and herby agree to all the terms stated above.

Patient or Responsible Party Signature Date

If Responsible Party, please complete below:

Printed Name

Address

For Notice of Privacy Practices only, describe the Responsible Party's authority to act on behalf of the patient and relationship

Prosthetic & Orthotic Solutions, LLC.

Patient Questionnaire & Demographic Form

	MRN# (office use)

Patient Legal Name	Date of Birth	Social Security Number
Address	City	State, Zip

•*If you reside in another state for a portion of the year please let us know!*

Home Phone	Work Phone	Cell Phone
Legal Gender	Email address	

Legal Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Employment Status: ☐ Employed ☐ Retired ☐ Disabled ☐ N/A, under 18 ☐ Full Time Student

If the patient is under 18, or has a legal guardian to make decisions for them please print their information below:

Legal Name	Date of Birth	Relationship
Emergency Contact (if different)	Phone Number	Relationship

Were you referred to us directly by a physician, friend or family member? If not, how did you hear about our practice or come to choose us for your prosthetic/orthotic needs?

Insurance

If you provided us with a copy of your cards you may skip the ID#'s

1	Primary Insurance:		ID#	
	Subscriber Name (if other than self)	Subscriber Date of Birth		Relationship to patient

2	Secondary Insurance:		ID#	
	Subscriber Name (if other than self)	Subscriber Date of Birth		Relationship to patient

3	Tertiary Insurance:		ID#	
	Subscriber Name (if other than self)	Subscriber Date of Birth		Relationship to patient

Patient Questionnaire

Is your injury related to an auto accident or a worker's comp claim?	☐ Yes ☐ No

Are you Diabetic?	☐ Yes ☐ No
If yes, do you have Type I or Type II diabetes?	☐ Type I ☐ Type II
If yes, does your primary care physician take care of your diabetes or do you see an endocrinologist?	☐ PCP ☐ Endocrinologist
Primary Care Physician:	
Endocrinologist: (if applicable)	

Height:	
Weight:	

If you are allergic any materials such as latex, please list them below:

Have you received the same device or a similar product to the one you're being seen for today?	
If yes, when did you receive this device? Date:	
If you did not receive this device from us which company provided it?	

Are you currently receiving home health services?	
If yes, what is the name of the home health agency? (i.e. Hartford Health at Home, Baystate VNA, Cooley VNA)	

Do you currently reside in a skilled nursing or rehab facility?	
If yes, which facility?	

Are you currently going to Wound Care?	
If yes, which facility? (i.e. Advanced Wound Care, HMC Wound Care)	

I certify that the answers to the questions above and information provided is true, accurate and complete.

> _____

Patient or Responsible Party Signature Date

If Responsible Party, please complete below:

_____
Printed Name

_____
Address

_____
Relationship to Patient