(Orthotic)

NEW HOPE PROSTHETIC & ORTHOTICS SERVICES, INC

PATIENT INFORMATION:

Today's Date: ___________ Patient Name: ____

If patient is a minor, please list the name(s) of parent(s) or legal guardian(s):

____ _______________________________________

Name & Relationship Name & Relationship

Date of Birth: ______________ Gender (circle): M F Soc Sec#: _______________________

Vocation (circle): Employed Student Homemaker Unemployed Disability Leave of Absence Retired

Patient's Employer: ____________________________________ Work Phone: (___)______________

Marital Status (circle): Single Married Divorced Widowed Spouse Name: ______________________

Home #: (___)______________ Cell #: (___)______________ Email: __________________________

Address: ____________________________________ City: _________________ State: ___ Zip: _______

Mailing Address (If different): ____

EMERGENCY INFORMATION:

Contact Name: ______________________________________ Phone #: __________________

Relationship to patient: ___________________________________

INSURANCE INFORMATION: Self Pay ___

Primary Insurance: ____

Insurance ID #: __________________________________ Group #: ____________________

Name of Insured IF other than patient: ______________________________ Date of Birth: _________

Secondary Insurance: ____

Insurance ID #: ___________________________________ Group #: _______________________

Name of Insured IF other than patient: ______________________________ Date of Birth: __________

If Workers Comp:

Insurance company name: ____

Claim #: _________________________ Case Manager Name & #: ________________________________

PHYSICIAN INFORMATION:

Referring Physician: ____

Address: ________________________________ City: __________________ State: ___ Zip: _________

Phone: (___)___________________ Fax: (___)____________________

Primary Care Physician: ____

Address: ________________________________ City: __________________ State: ___ Zip: _________

Phone: (___)___________________ Fax: (___)____________________

Physical Therapist (if applicable): _________________________________ Phone: (___)_____________

MEDICAL HISTORY: **(Orthotics)**

General Health (check): Poor_ Fair_ Good_ Excellent_ Height: ____ Weight: ____ Shoe Size: _____

Patient currently has or had (check all that apply):

	Heart Problems		Hepatitis C		MRSA
	Hypertension		Vascular Disease		Pacemaker/Defibrillator
	Osteoporosis		Rheumatoid Arthritis		HIV Positive
	Stroke		Osteoarthritis		Seizure Disorder
	Diabetes		Respiratory Disease		Hearing Loss
	Kidney Disease		Vision Problems		Currently Pregnant

Any other conditions not listed above: ____

List any known allergies (including contact materials): ____________________________________

____

Is this your first orthosis (brace)? Yes __ No __ If no, please answer the following questions:

When were you last fit? ____________ Name of facility: ___________________________________

What were you fit with and why? ____

____

If Diabetic list physician treating you: ____

Are you currently taking medication to treat your diabetes? Yes __ No __

Have you received diabetic shoes and/or insoles within the past year? Yes __ No __

Do you authorize your practitioner to take photo's or video of you for your medical record? Yes __ No __

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INSURANCE AUTHORIZATION AND MEDICAL RELEASE

I certify that the information provided is true, accurate and complete. I hereby authorize my insurance company(s), Medicaid and/or Medicare to pay directly to New Hope Prosthetic & Orthotic Svcs, Inc. all benefits due for services furnished by the aforementioned. Additionally, this authorization includes any secondary insurance coverage I currently have. I understand that for all charges not covered by insurance or any other source, including collection fees, I am financially responsible to New Hope Prosthetic & Orthotic Svcs, Inc. I authorize New Hope Prosthetic & Orthotic Svcs, Inc to obtain or release medical records to whomever they deem appropriate to facilitate my care. Patient confidentiality will be maintained. A photocopy of this agreement is to be considered as valid as the original. This assignment will remain in effect until revoked by me in writing.

HIPAA-Notice of Privacy Practices - This notice describes how medical information about you may be used and disclosed and how you can get access to this information. *For your personal copy to review, please ask for a printout.*

MEDICARE DMEPOS SUPPLIER STANDARDS - Note: This is an abbreviated version of the supplier standards every Medicare DMEPOS supplier must meet in order to obtain and retain their billing privileges. These standards, in their entirety, are listed in 42 C.F.R. 424. *For your personal copy to review, please ask for a printout.*

_______________________________________ ____________ ______________________________

Signature of Patient or Personal Representative | Date | Description of Personal Representative (if needed)