**ABILITY** PROSTHETICS & ORTHOTICS

## *ABILITY* Prosthetics & Orthotics: PATIENT INFORMATION

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|---|---|
| **Last Name, First Name, Phone** | **Phone:**_____ |
| **Address** | |
| **City, State, Zip** | |
| **Emergency contact** | **Phone:**_____ |
| **Date of Birth & SSN#** | |
| **Email** | |
| **Insurance Information** | **Primary:**_____ **Secondary:**_____ **Tertiary:**_____ |
| **Insured Name, DOB & Policy ID#** | **Name:**_____ **DOB:**_____ **SSN:**_____ **Policy ID#** |
| **Parent or Responsible Party** | **Name:**_____ **DOB:**_____ **Phone:**_____ **SSN:**_____ |
| **PHYSICIAN INFORMATION** | **REFERRING PHYSICIAN:**_____ |
| **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.<br>• **Purpose of Consent:** By signing this form, you consent for *ABILITY* Prosthetics & Orthotics to use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations |
| **COMMUNICATION AUTHORIZATION** | I authorize *ABILITY* Prosthetics & Orthotics 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 ABILITY Prosthetics & Orthotics 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 *ABILITY* Prosthetics & Orthotics. 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 *ABILITY* Prosthetics & Orthotics. |
| **SIGNATURE** | **I HAVE READ, UNDERSTOOD, AND HEREBY AGREE TO ALL OF THE TERMS STATED ABOVE.**<br>_____ _____<br>**PATIENT OR AUTHORIZED REPRESENTATIVE SIGNATURE:** **DATE:**<br>**Relationship to patient:**_____ |