AMERICAN ORTHOTIC & PROSTHETIC CENTER
THE LEADERS IN NEW TECHNOLOGY

PATIENT INFORMATION

Name: _____ **Date:** _____

Address: _____ **Apt:** _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____ **Email:** _____

Birthdate: _____ **Social Security #:** _____ **Male/Female:** _____

PARENT OR LEGAL GUARDIAN IF PATIENT IS A MINOR OR RESPONSIBLE PARTY (IF DIFFERENT FROM PATIENT)

Name: _____ **Relationship to patient** _____

Address: _____ **Apt:** _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____ **Email:** _____

PHYSICIAN INFORMATION

Referring Doctor: _____ **Phone:** _____

City: _____ **State:** _____ **Zip:** _____

If Diabetic, Doctor treating Diabetes: _____ **Phone:** _____

City: _____ **State:** _____ **Zip:** _____

HEALTH INSURANCE INFORMATION

PRIMARY Insurance: _____ **Policy ID #:** _____

Address: _____ **Group #:** _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____

Subscribers Name: _____ **Relationship to Patient:** _____

SECONDARY Insurance: _____ **Policy ID #:** _____

Address: _____ **Group #:** _____

City: _____ **State:** _____ **Zip:** _____

Insurance Phone #: _____

Subscribers Name: _____ **Relationship to Patient:** _____

WORKER'S COMPENSATION INFORMATION

Is this a work ☑ **auto** ☐ **other** ☐ **accident? Date of injury/accident:** _____

Name of worker's compensation claim carrier _____ **Claim ID#** _____ **Adjuster** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

ACTIVE DUTY OR VETERAN INFORMATION

Active duty_☐_ Retired_☑_Branch of Service_____Are you treated at the Veteran's Administration clinic?_____

If answer is yes, which VA clinic_____Doctor'sname_____Date of last visit with doctor_____

Last four of your social security #:_____

EMPLOYMENT HISTORY

Currently employed? _☐_yes _☑_no

If yes, company name _____

How long?_____

If no, when was the last time you were employed? Year(s)_____

Company name _____

BENEFITS, MEDICAL INFORMATION RELEASE AUTHORIZATION & ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

Although we make every effort to obtain accurate information from the insurance carrier, verification of benefits is not a guarantee that an insurance carrier will pay a claim. The insurance carrier makes final determination based upon the plan's level of coverage and associated policies, upon receiving the claim. Patient is ultimately responsible for payment of bills and any deductibles or co-insurance as determined by patient's insurance carrier contract.Denied claims become the responsibility of the patient. I authorize American Orthotic & Prosthetic Center to release any information required for payment of insurance claims. I authorize my insurance or Medicare benefits to be paid directly to the provider, realizing I am responsible to pay non-covered and unauthorized services.I agree to notify American Orthotic & Prosthetic Center immediately of any change in insurance coverage or status.

If my account is referred for collection, I agree to pay the cost of collection, including a $20.00 collection fee and all attorney fees if litigation is necessary.

Signature of Patient or Legal Guardian _____ Date: _____

Initial: _____ Medicare patient's only – (Received a copy of the HCFA Supplier Standards)