WALKER ORTHOTICS & PROSTHETICS

205 Redmond Rd. Rome, Ga 30165

(706) 232-4383

Patient Information Form-Please Print

Patient's Name: Last_____ First_____ MI____

Date of Birth: ____/____/____ Age: _____ Social Security #_____-_____-_____

____Male ____Female Parent/Guardian if above is a child or minor_____

Marital Status: ( )Married ( )Single ( )Divorced ( )Widowed ( )Separated Other:_____

Address:_____ ( )Home ( )Nursing Home Other_____

City:_____ State_____ Zip_____

Phone # ( )_____ Work Phone # ( )_____

Employer: _____ Occupation:_____

Cell Phone # (_____) EMAIL ADDRESS _____

INSURANCE INFORMATION

Please complete this information if the insurance is NOT thru patient

Primary Insurance Company Name:_____

Name of Insured:_____ Insured's SS#_____/_____/_____

Employer:_____ Group # _____

Relationship to Patient:_____ Insured's Date of Birth: ____/____/_____

Secondary Insurance Company Name:_____

Name of Insured:_____ Insured's SS#_____/_____/_____

Employer:_____ Group #_____

Relationship to Patient:_____ Insured's Date of Birth:_____

RESPONSIBLE PARTY

Please complete information if different from patient

Full Name:_____ Social Security #_____/_____/_____

Address:_____

Relationship to Patient:_____ Date of Birth: ____/____/_____

Phone #_____ Work Phone #:_____

ADDITIONAL INFORMATION

Emergency Contact: (Someone not living with you)Name:_____

Phone #_____ Relationship_____

Referring Physician_____ Phone #_____

Primary Physician _____ Phone #_____

I understand that I am financially responsible for all charges whether or not paid by Insurance. I hereby authorize Walker Orthotics and Prosthetics to release all information necessary to secure payment of benefits. I hereby authorize orthotic/prosthetic services for the above "patient" at any time when prescribed by a physician. I hereby authorize payment directly to Walker Orthotics and Prosthetics, Inc. for any services furnished to me. All compression garments and/or Custom made items are non returnable.

Date:_____ Signature:_____

Relationship (if other than patient):_____

WALKER ORTHOTICS AND PROSTHETICS

Financial Policy

Thank you for choosing WALKER ORTHOTICS AND PROSTHETICS as your health care provider. We are committed to providing you with quality products and the best possible care. In order to achieve these goals, we feel it is important that you understand our financial policies for services rendered at WALKER ORTHOTICS AND PROSTHETICS.

1. Payment is due at the time services are rendered unless financial arrangements have been approved in advance.

2. We accept Cash, Checks, VISA and Mastercard

3. If you have insurance, we will be happy to submit your claims directly to your insurance company. However, it is important for you to understand that your insurance policy is a contract between you and your employer and your insurance company. WALKER ORTHOTICS AND PROSTHETICS relationship is with you, not your insurance company. As a result, you are responsible to pay for all charges incurred at Walker Orthotics and Prosthetics

4. Services rendered for dependents (children) are to be paid for by the parent who brings the child to the office for treatment regardless of marital or divorce status.

5. In the event your account is placed with a collection agency, you agree to pay 30 percent of the principal and interest owing on said account as liquidation damages, and an additional 15 percent of the principal and interest owing as attorney's fees, for collecting said account.

INSURANCE POLICIES

WALKER ORTHOTICS AND PROSTHETICS participates with many insurance companies. In order to accept your insurance, we require that your policy be verified by our office staff before services are rendered. Some insurance companies require prior authorization or referral before any type of work can be started. For these cases, it is important for you to realize that we have to wait for these referrals in order to minimize any out-of-pocket expenses you may incur.
When confirming benefits and eligibility, verbal authorization obtained from your insurance company do not guarantee that services are covered under provisions of your policy. Please be aware that some insurance companies arbitrarily select certain services that will not be covered. If your insurance does not remit payment to WALKER ORTHOTICS AND PROSTHETICS within 60 days from date of service, you will be billed for any outstanding balances. If you can not pay your account within this time period, we will be happy to discuss possible credit arrangements with you to resolve your account. If you have any questions, please call WALKER ORTHOTICS AND PROSTHETICS, 706-232-4383. We are here to help you.

I understand and agree that should my insurance company refuse approval of services rendered, I am ultimately responsible for the balance on my account for services rendered at WALKER ORTHOTICS AND PROSTHETICS.

SIGNATURE:_____ DATE_____

ASSIGNMENT OF PROVIDER RIGHTS TO PAYMENT

PATIENT'S NAME:_____ MEDICARE # IF APPLICABLE:_____
(PRINT PLEASE)

I request that payment of authorized Medicare or other insurance benefits be made either to me or on my behalf to Walker Orthotics & Prosthetics for any services furnished me by that supplier. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents (or other insurances) any information needed to determine these benefits or the benefits payable for related services.

SIGNATURE:_____ DATE:_____

WALKER ORTHOTICS AND PROSTHETICS

CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Use and Disclosure of Your Protected Health Information:

Your protected health information will be used by Walker Orthotics & Prosthetics, Inc. or disclosed to others for the purpose of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice. In addition, my medical records may be shared with the following:

Name:_____ Relationship:_____
Name:_____ Relationship:_____
Name:_____ Relationship:_____
Name:_____ Relationship:_____

It may be necessary for us to reach you by telephone with information regarding such things as appointments, receipt of your orthosis/prosthesis, insurance information, etc. If you are not available at the phone number (s) you have provided to us, may we leave a message on an answering machine? ___Yes____ No? OR may we leave a message with someone listed above or as your emergency contact ___Yes ____No?

Notice of Privacy Practices:

You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information:

You may request a restriction on the use or disclosure of your protected health information.

Walker Orthotics & Prosthetics, Inc. may or may not agree to restrict the use or disclosure of your protected health information.

If Walker Orthotics & Prosthetics, Inc. agrees to your request, the restriction will be binding on the practice. Use or disclosure or protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent:

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Signature

I have reviewed this consent form and give my permission to Walker Orthotics & Prosthetics, Inc. to use and disclose my health information in accordance with it.

Name of Patient (Print or Type):_____

Signature of Patient: _____

Or Signature of Patient Representative:_____ **Relationship**_____

I have executed the above document for the patient because: (Check below)

_____It is impractical for the Patient to execute this document because of the patient's mental or physical condition is such that the patient should not be asked to transact business.

_____The patient is a minor.

Date:_____

WALKER ORTHOTICS & PROSTHETICS

205 REDMOND RD

ROME, GA 30165

RECORDS RELEASE

DATE:_____

I, _____, HEREBY AUTHORIZE THE FOLLOWING DOCTOR (S) OR MEDICAL FACILITY (please list any physician, therapist, surgeon ,etc that is treating you for condition being seen at our office)

_____

_____

TO RELEASE MEDICAL RECORDS REGARDING _____ TO WALKER ORTHOTICS & PROSTHETICS INCLUDING THE DIAGNOSIS AND RECORDS OF TREATMENT AND/OR EXAMINATION RENDERED TO ME UNDER THEIR CARE.

PATIENT SIGNATURE:_____

OR PATIENT REPRESENTATIVE:_____

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Rome, GA 30165

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EQUIPMENT WARRANTY INFORMATION FORM

Every product sold or rented by our company carries a manufacturer's warranty.

Walker Orthotics & Prosthetics will notify all Medicare beneficiaries of

the warranty coverage, and we will honor all warranties under applicable law.

Walker Orthotics & Prosthetics will repair or replace, free of charge,

Medicare-covered equipment that is under warranty. In addition, an owner's manual/instruction

pamphlet with warranty information will be provided to beneficiaries for all durable medical equipment,

orthotic or prosthetic device(s) where this manual/instruction pamphlet is available.

I have been instructed and understand the warranty coverage on the product I have

received.

Beneficiary Signature_____ Date:_____