Patient Information Form

PATIENT INFORMATION

Last Name:	First Name:	Middle Initial:	Preferred Name:

Date of Birth:	Gender: (check one) Male ☐ Female ☐	SSN:	E-mail address:

Mailing Address: City State Zip Code	Marital Status:

Cell phone:	OK to leave message? Yes ☐ No ☐	Primary Language:	Referring Doctor:	Primary Care Doctor:

EMERGENCY CONTACT/WHO WE CAN COMMUNICATE WITH REGARDING APPOINTMENTS AND MEDICAL INFORMATION

Name: (First, Last)	Relationship to Patient	Phone Number:	Okay to Leave a Message
			Yes ☐ No ☐
			Yes ☐ No ☐

RESPONSIBLE PARTY (PARENT/GUARDIAN)

Guarantor Name:	Address:	Phone Number:	OK to leave message? Yes ☐ No ☐

E-mail Address:	Date of Birth:	Relationship to Patient:

ADDITIONAL INFORMATION

Are you currently or have you recently worked with a physical and/or occupational therapist? Yes ☐ No ☐	If yes, **Name of Therapist**_____

Yes ☐ No ☐ Have you received a like or similar device within the last 5 years from either OrthoPro or any other provider?

Yes ☐ No ☐ Are you currently residing in a nursing home, assisted living or group home?
If yes, Name of Facility **Phone number:**

Yes ☐ No ☐ Have you received a motorized wheelchair within the last 5 years?

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INSURANCE INFORMATION

Is this self-pay? Yes No

Patient or Guardian Employer Name: Phone Number:

Is this a Worker's Comp Claim? Yes No If yes, please fill out below:

Employer at Time of Injury:	Date of Injury:
Claim Number:	Carrier Name:
Adjuster Name:	Adjuster Phone Number:

Please fill out insurance information below if you do NOT have insurance card with you

Primary Insurance Company		ID#		
Subscriber Name:	Relationship to Patient	Phone#	DOB:	SSN:
Secondary Insurance Company		ID#		
Subscriber Name:	Relationship to Patient	Phone#	DOB:	SSN:

Consent for Contact: I, the undersigned, consent to be contacted by OrthoPro by phone call, text, e-mail, USPS or other means to follow-up on and provide reviews of my care.

Consent to Coordinate Care and Release of Medical Records: By signing below, I authorize all medical personnel to provide information to OrthoPro concerning my medical history, as it may relate to my treatment. This includes collecting medical information from any physician, surgeon, medical facility and/or physical therapist seen by me. OrthoPro will comply with all HIPAA rules and regulations.

Patient/Guardian Signature:	**Date:**

Payment Policy

Thank you for choosing us for your prosthetic and orthotic needs. We are committed to providing you with quality and affordable health care. Please read our payment policy, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Custom Devices**. **If you are being provided with a custom device it cannot be returned**. We will make adjustments needed to ensure the devices fits properly. If your device is made and you do not show up for delivery your insurance will still be billed for the device since it cannot be returned.
2. **Prosthetic Supplies (liners, sleeves, socks), non-stock, and special order items:** May not be returned or refunded. All other items will be reviewed on a case by case basis.
3. **Insurance.** It is your responsibility to know your healthcare coverage. We participate with most insurance plans, including Medicare. We do not participate with United Healthcare, some Cigna & Aetna plans and other insurance companies. If you are not insured by a plan we are contracting with, payment is due in full when fabrication begins. If you are insured by a plan that we are contracting with, your portion of the payment for services provided will be due before fabrication.
4. **Benefits.** Knowing your insurance benefits is your responsibility. You are responsible for your entire bill should your insurance company not pay any of the anticipated charges for any reason. Please contact your insurance company with any questions you may have regarding your policy. If you need help in doing so please let us know, we would be happy to assist you.
5. **Deductible and Co-insurance.** We require that all co-payments are made on the day of your visit. We are unable to set-up payment arrangements. We accept cash, check, Visa/MasterCard and Care Credit.
6. **Non-covered services.** Please be aware that some -and perhaps all- of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. This is why it is very important to check your benefits before your visit.
7. **Proof of Insurance.** All patients must provide complete insurance information before seeing a practitioner. We must obtain a copy of your current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim.
8. **Claims Submission.** We will submit your claims and assist you in any way reasonable to help get your claims paid. Your insurance company may need you to supply certain information directly to them. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not a party to that contract. If your insurance company has not paid on services within 45 days, we ask that you contact them with regards to their processing.
9. **Coverage Changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.
10. **Nonpayment.** If your account is over 60 days past due, we will add a finance charge of $10 per month. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members will no longer be able to obtain service through our office.
11. **Missed appointments.** We will not charge for missed appointments. After multiple missed appointments you will no longer be scheduled into our office and you will be referred back to your physician.
12. **Minor patients.** It is our policy that an adult will accompany minor patients. The parent who accompanies the minor to our office is responsible for the charges incurred and billings to any other party.
13. **Returned Checks.** For all returned checks there will be a $25.00 charge.

Our office is committed to providing the best treatment to our patients. Thank you for understanding our financial policy. If you have any questions regarding this payment policy, please refer them to the administrative team.

I, the undersigned, herby authorize OrthoPro to request on my/our behalf & to collect directly all public and private insurance benefits due for products and/or services supplied to me by OrthoPro. In the event payments for insurance benefits are made directly to any of the undersigned, the payee will endorse to OrthoPro all checks for such payments.

I have read and understand the Payment & Policy agreement. I also certify the information provided by me is true, accurate and complete to the best of my knowledge.

Patient/Parent/Guarantor Signature:	**Date:**

1437 Parkview Drive, Suite 200, Twin Falls, ID 208-733-0505
1600 Overland Ave, Suite C, Burley, ID 208-878-0500

PHOTO CONSENT FORM

Patient Name:_____ **Date:**_____

Photos & videos of patients will be taken as part of your medical record to document goals & outcome measures and to help with medical necessity justification for insurance payment, if needed.

I consent for medical photographs and/or videos to be taken of me by OrthoPro of Twin Falls or a representative. I understand that the information may be used in my medical record or for purposes of medical teaching. By consenting to these medical photographs and/or videos I understand that I will not receive payment from any party. Although these photographs and/or videos will be used without identifying information such as my name, I understand that it is possible that someone may recognize me. Refusal to consent to photographs will in no way affect the medical care I will receive. If I wish to withdraw my consent in the future, I may do so with a written request.

I authorize the use of images: (Please initial indicating YES or NO below)

_____ YES _____ NO For demonstration purpose including an office photo album

_____ YES _____ NO On our website or social media for prospective patients

_____ YES _____ NO In print advertisements

By signing this form below, I confirm that this consent form has been explained to me in terms which I understand.

Patient/Parent/Guardian Signature:	Date:

1437 Parkview Dr, Suite 200, Twin Falls, ID 83301 Phone: 208-733-0505, Fax: 208-734-0766
1600 Overland Ave, Suite C, Burley, ID 83318, Phone: 208-878-0500, Fax: 208-734-0766

CONSENT FOR RELEASE OF PROTECTED PERSONAL HEALTH INFORMATION (PHI)

This form is used to authorize consent for OrthoPro of Twin Falls, Inc to communicate protected health information.

Patient whose information will be released:

Name:_____ **Date of Birth:**_____ **Today's Date:**_____

Address:_____

Information to be released:

Protected health information OrthoPro and its affiliates maintain related records related to your prosthetic and/or orthotics devices including medical records and finances. This information may be disclosed to, and used by, the following person or organization to assist me with care provided by OrthoPro. I understand this authorization will allow OrthoPro and its affiliates to use or disclosed the protected health information described above.

Person Information will be released to:

- ○ Spouse
- ○ Parent
- ○ Child
- ○ Sibling
- ○ Friend
- ○ Agent/Broker
- ○ Organization

Name:_____ **Date of Birth:**_____ **Phone number:**_____

Information of person checked above

Address:_____

I authorize release of my medical records as listed above and understand that my authorization will remain in effect unless I cancel by submitting written notice to OrthoPro. If I cancel authorization, it will not apply to any information previously released with this authorization. Once information is shared, OrthoPro cannot prevent the person or organization who has access to it from sharing that information with others, and this information may not be protected by federal privacy regulations.

Patient/Parent/Guardian Signature:_____ **Date:** _____

Please fill out a separate form for each entity to which information may be released