RELIABLE PROSTHETICS AND ORTHOTICS, LLC.

1314-B COMMERCE DR., NEW BERN, NC 28562 *P: 252-638-8989 / F: 252-638-5989*
12 OFFICE PARK DRIVE, JACKSONVILLE, NC 28546 *P: 910-353-9002 / F: 910-353-9003*
229 PROFESSIONAL CIRCLE, MOREHEAD CITY, NC 28557 *P: 252-773-0046 / F: 252-773-0086*

_____
FIRST MI LAST

DOB: _____/_____/_____ SSN: _____-_____-_____

_____
ADDRESS CITY STATE ZIP

_____ _____ _____
HOME PREFERRED? ☐ CELL PREFERRED? ☐ WORK

Are you Diabetic or Insulin Dependent?
☐ Yes ☐ No

_____
SHOE SIZE HEIGHT WEIGHT AGE GENDER

REFERRAL INFORMATION:

(Required) Prescribing Physician: _____ Phone:( )_____

Primary Physician: _____ Phone:( )_____

Diabetic Physician: _____ Phone:( )_____

INSURANCE INFORMATION: *(MUST BE COMPLETED BY PATIENT)*

Primary Insurance: _____ Policy #: _____

Policy Holder: _____ Policy Holder's DOB: _____/_____/_____

Secondary Insurance: _____ Policy #: _____

Policy Holder: _____ Policy Holder's DOB: _____/_____/_____

Tertiary Insurance: _____ Policy #: _____

Policy Holder: _____ Policy Holder's DOB: _____/_____/_____

Have you received a similar item in the past 5 years? *Yes* _____ *No*_____

Workers Comp. Injury? Claim #: _____

(All are required for services) **Contact:** _____ **Phone:** _____

_____
Patient / Authorized Representative Name

_____
SIGNATURE **DATE**

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PATIENT ACKNOWLEDGEMENT

Please Review and Sign when Complete

Patient First Name: _____ Patient Last Name: _____ Date of Birth: _____

I consent to treatment under the recommendations of the Orthotist/Prosthetist and authorize the release of medical or other necessary information between **Reliable Prosthetics and Orthotics** for treatment purposes. A photocopy of this authorization is considered valid. I acknowledge receipt of the Notice of Privacy Practices and Patient Bill of Rights. For custom and off-the-shelf devices, no refunds will be issued unless a device is deemed defective or inappropriate at the time of fitting by the clinician.

I understand that providing incomplete or inaccurate demographic, insurance, or referring physician information may result in personal financial responsibility for all services and devices provided. I understand that a valid prescription from a face-to-face physician encounter (preferably within 3 months) is required prior to receiving services, and I may need to obtain an updated prescription if this requirement is not met.

I understand that I am responsible for any applicable deductibles, coinsurance, co-payments, and any non-covered or denied amounts. If assignment is accepted under Medicare, the provider agrees to accept the Medicare-approved amount as payment in full for covered services, except for my cost-sharing responsibilities. I assign and authorize direct payment of any and all benefits, including Medicare, Medicaid, and commercial insurance, for durable medical equipment (DME), orthotics, prosthetics, supplies, and related services provided by **Reliable Prosthetics and Orthotics**, to be made directly to the provider as the undersigned patient or authorized representative. I authorize **Reliable Prosthetics and Orthotics** to submit claims on my behalf and to take all actions necessary to obtain payment in accordance with applicable payer requirements, including those of the Centers for Medicare & Medicaid Services (CMS) and other insurers. I certify that all information provided is true and complete and authorize the release of any medical or other information necessary to process claims and secure payment. I also authorize my insurance carrier(s), including CMS, to communicate directly with the provider. This assignment and authorization shall remain in effect until revoked in writing. A copy or electronic version shall be as valid as the original.

(For Medicare Patients Only) I understand that a Standard Written Order will be generated following today's services and sent to my physician for signature. Supporting physician documentation is required to meet Medicare claim requirements. If documentation is missing, incomplete, or does not establish medical necessity, I may be responsible for obtaining updated documentation or scheduling a follow-up appointment with my physician. I understand I may request a copy of the applicable Medicare Local Coverage Determination Policy. I also understand that an Advance Beneficiary Notice of Non-Coverage may be issued if Medicare denial is likely. I acknowledge receipt/review of Medicare Supplier Standards.

_____

Patient / Authorized Representative Name

_____

SIGNATURE **DATE**

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HIPAA Compliance & Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive. By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? **YES / NO**

- I understand that email and text messages are not considered a completely secure form of communication and I am authorizing Reliable Prosthetics and Orthotics to send emails and/or text messages which may contain my protected health information to the following cellular devices and/or email accounts. I understand that I may change or rescind this authorization at any time by contacting Reliable Prosthetics and Orthotics.

May we discuss your medical condition with any member of your family? **YES / NO**

If YES, please name the members allowed:

Name: _____ Relation: _____

Name: _____ Relation: _____

_____

Patient / Authorized Representative Name

_____

SIGNATURE **DATE**

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INTAKE QUESTIONNAIRE

The following questions are relating to the service(s) you are visiting us for. Please answer to the best of your ability. If you feel a section does not apply to you, please put "N/A".

1. Patient Name: _____
2. Current pain level: **1 2 3 4 5 6 7 8 9 10**
3. When did injury/symptom occur? _____
4. What activity caused your injury? _____
5. What are your symptoms? _____
6. What activities increase your pain level? _____
7. Have you had any surgical procedures pertaining to your visit today? If "yes", please explain: _____

_____

8. Any additional necessary info that pertains to your visit: _____

_____

_____
Patient / Authorized Representative Name

_____
SIGNATURE **DATE**