YAKIMA ORTHOTICS & PROSTHETICS, PC

PATIENT INFORMATION:

Todays Date: ______________________ Age: ________ Male:_______ Female: _______

Patient Name: ______________________________ Date of Birth: ______________________________

Mailing address: ______________________________ Home Phone: ______________________________

______________________________ Work Phone:______________________________

______________________________ Cell Phone: ______________________________

RESPONSIBLE PARTY:

Bill to :______________________________ Relationship to patient: ______________________

Bill to address: ______________________________ SSN: ____________________

____

Name of Employer or School: ______________________________Phone: ________________

INSURANCE INFORMATION:

It is your responsibility to provide our office with your current insurance information. Please present your insurance information at every visit, and promptly notify us of any changes in your eligibility.

Primary:______________________________ Secondary: ______________________________

Subscriber:_________________ DOB:_________ Subscriber: _________________ DOB: __________

ID #: ______________________________ ID #: ______________________________

Group #: ______________________________ Group #: ______________________________

Subscriber's Employer: ______________________ Subscriber's Employer: ______________________

MEDICARE PATIENTS ONLY:

I request that payment of authorized Medicare benefits be made to YAKIMA ORTHOTICS & PROSTHETICS, PC for any services furnished to me by the supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its' agents any information needed to determine these benefits or the benefits payable for related services.

Beneficiary: ______________________________ HICN: ______________________________

Signature: ______________________________ Item: ______________________________

Date : ______________________________

OTHER INSURANCE:

Is this a work related claim: Y or N DOI: ____________ Claim #: ______________________

Is this a Auto Accident Claim: Y or N DOI: ____________ Claim #: ______________________

Name of Insurance company: ______________________________

Claim Manager Name: ______________________________ Phone #: ______________________

MEDICAL INFORMATION:

Primary Doctor: ______________________________ Phone #: ______________________

Referring Doctor: ______________________________ Phone #: ______________________

Physical Therapist: ______________________________ Phone #: ______________________

YAKIMA ORTHOTICS & PROSTHETICS, PC

Patient name: ______________________________ **DOB:** ____________________

PATIENT MEDICAL HISTORY:

(please mark all that apply) Height: __________ Weight: __________

HEART PROBLEMS BACK PROBLEMS DIABETES ARTHRITIS

STROKE CIRCULATION PROBLEMS RESPIRATORY DISEASE

AMPUTATION Date of Amputation: ________________________

Level of Amputation:___above knee ___below knee ___foot only___ toes only

___ above elbow ___below elbow

Your physician is prescibing an orthopedic or prosthetic device. Please indicate if you have received a similar device from another facility within the last 24 months. Yes____ or No ____

If yes, please give approximate date received. Date received: __________________________

What is the reason for your visit today? ____

____

When did you last see your physician for the above mentioned condition or concerns? ______________

FINANCIAL ARRANGEMENTS:

Please read carefully.

Payment is due at the time of service, unless other arrangement have been made.

As a courtesy to you, we will bill all first and second insurance company claims. Please advise us if you do NOT want us to file your insurance claim for you.

In order to prevent a Misunderstanding about our fees and your medical insurance, we want our patients to know that:

A. YOUR INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. THEREFORE, YOU ARE LIABLE FOR THE BILL. NOT YOUR INSURANCE COMPANY.

B. In many cases your insurance will only pay a part of our fees. Since our relationship is with you, our bill is your responsibility. There is never a guarantee of payment from your insurance company.

C. If you have a balance on your account that is your responsibility, we will send you an invoice. We ask that you pay your personal balance in full. We accept cash, check, and major credit cards, VISA, MASTERCARD, AMERICAN EXPRESS & DISCOVER. We also have a payment plan called Care Credit, that allows you to pay your portion today and spread payments over time. Go to ***www.carecredit.com*** for more information.

D. Payments that are overdue by more than 90 days, may be sent to collections.

E. It is your responsibility to check with your insurance company regarding preferred provider status prior to being seen. If we are not a preferred provider for your insurance company, that will mean more out of pocket expense to you.

Your signature on this form constitutes your agreement to the above policy and all of the conditions herein and authorizes direct payment and assignment of your benefits from your insurance company.

Signature: ______________________________ Date: ____________________