RELIABLE PROSTHETICS AND ORTHOTICS, LLC.

NBO P#: 252-638-8989/F#: 252-638-5989 *JAX OFFICE P#: 910-353-9002/F#910-353-9003*

GENDER: MALE / FEMALE

_____
HEIGHT **WEIGHT** **AGE**

__ __ __ __ __ __ __ __ __ - __ __
BENEFIT ID NUMBER
(*LOCATED BACK OF MILITARY ID)*

_____ /_____ /_____
DATE OF BIRTH

_____ _____ _____
FIRST NAME **MI** **LAST NAME**

_____
ADDRESS *(BARRACKS IS ACCEPTABLE)* **CITY** **STATE** **ZIP**

(_____)_____ (_____)_____
HOME PHONE **CELL PHONE**

_____
REFERRING PHYSICIAN

_____
PRIMARY INSURANCE **POLICY HOLDER** **POLICY HOLDER D.O.B.**

Consent for treatment, release of Medical Information and Receipt of Notice of Privacy Practice:

PERSONS ABLE TO RECEIVE MEDICAL INFORMATION:

_____

_____

I, the undersigned, do hereby consent to treatment under the recommendations and the instructions of the Orthotist / Prosthetist.
I authorize any holder of medical or other information about me, to release such information as may be necessary for the completion of my treatment. A photo copy of this authorization is considered valid. I understand that I am responsible for all copayments, deductibles, and/or payments for services on claims which insurance benefits may be limited or non-existent.

By consenting to the procedure prescribed by my physician, and due to the inherent cost associated with custom fabrication, I understand that there can be no refund for custom fabricated orthotics or prosthetics, unless the item is proved to be substandard (less than full quality) or inappropriate at the time of fitting. By my signature below, I acknowledge that I have received the companies Notice of Privacy Practices, Patient Bill of Rights and Medicare Supplier Standards.

_____
SIGNATURE **DATE**