RELIABLE PROSTHETICS AND ORTHOTICS, LLC.

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

_____

FIRST MI LAST

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

_____

ADDRESS CITY STATE ZIP

_____ _____ _____

HOME CELL WORK

MARITAL STATUS: S M D W

_____

HEIGHT WEIGHT AGE GENDER

REFERRAL INFORMATION:

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:** _____

AUTHORIZED TO RELEASE MEDICAL INFO TO: _____

I Consent for treatment, Release of Medical Information & Acknowledgement of Financial responsibility & receipt of Notice of Privacy Practices: I, the undersigned, do hereby consent to treatment under the recommendations and 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 photocopy of this authorization is to be considered valid. I understand that I am personally 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 a custom fabricated Orthosis / Prosthesis, 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 or Rights and Medicare Supplier Standards.

_____

SIGNATURE **DATE**