PATIENT REGISTRATION FORM

CREATIVE PROSTHETICS & ORTHOTICS, LLC

PLEASE PRESENT *INSURANCE CARDS* AT THE WINDOW WITH THIS FORM

ALL INFORMATION MUST BE COMPLETED

1. *PATIENT INFORMATION*

Patient's FULL Name: _____ **Patient's DOB:**_____
LAST FIRST MI

Patient's Address: _____

City _____ State _____ Zip _____

*Cell Phone: _____ Home Phone: _____

***EMAIL ADDRESS**: _____

Sex: _____M _____F Height: _____ Weight: _____

Parent/Legal **Guardian**/Spouse/Emergency Contact: _____

Guardian's Date of birth: _____ Phone/Cell: _____

PRESCRIBING PHYSICIAN _____

DIAGNOSIS_____ **DATE OF ONSET/INJURY** _____

2. INSURANCE INFORMATION

PRIMARY Insurance Carrier _____ Group Name/#_____

Policy/Member ID#: _____ POLICY HOLDER'S NAME: _____

POLICY HOLDERS SS#: _____ **DOB**_____ Relationship to patient_____

SECONDARY Insurance Carrier _____ Group Name/#_____

Policy/Member ID#: _____ POLICY HOLDER'S NAME: _____

POLICY HOLDERS SS#: _____ **DOB**_____ Relationship to patient_____

Authorization to Release Information to Necessary vendor/insurers to manufacture or bill required device.

I hereby authorize CREATIVE PROSTHETICS & ORTHOTICS, LLC to release only necessary information, including photographs, about me (patient) in order for my prescribed device(s) to be manufactured or reimbursed.

****Authorization for Future Contact – Cell Phone /Email Permission****

I hereby authorize CREATIVE PROSTHETICS & ORTHOTICS, LLC to contact me by my home, cell phone number, or email, at any time in the future to provide me with additional information to enhance the fit and function of my orthotic/prosthetic devices and treatment.

**** Authorization To Pay Benefits To CREATIVE P&O/Authorization to Release Information ****

I hereby authorize payment directly to CREATIVE PROSTHETICS & ORTHOTICS, LLC for any services I receive during my treatment. I give permission to CREATIVE PROSTHETICS & ORTHOTICS, LLC to release any information to my insurance company, attorney, assignees and/or beneficiaries.

**** Financial Responsibility ****

The undersigned guarantees payment to CREATIVE PROSTHETICS & ORTHOTICS, LLC for services rendered in the event insurance does not cover all fees. I am responsible for payment if the insurance carrier decides this is a non-covered service or requires pre-authorization, which I did not obtain.

MEDICARE/MEDICARE REPLACEMENT PATIENTS:
I HAVE RECEIVED COPY (OR NOTICE) OF THE SUPPLIER STANDARDS_____
PATIENT/PARENT/LEGAL GUARDIAN/SPOUSE/ GUARANTOR

Signature: _____ Date: _____
PATIENT/PARENT/LEGAL GUARDIAN/SPOUSE/ GUARANTOR