# ‹‹‹ ‹‹‹ ‹‹‹ ‹‹‹ ALPHA-OMEGA ››› ››› ››› ›››

## ORTHOTICS & PROSTHETICS, INC.

**Toll Free:** 888.758.0717

**DATE:** ________________

**PATIENT INFORMATION**

PATIENT NAME: ______________________________ PHONE #: ____________________

ADDRESS: ______________________________ DATE OF BIRTH: ________________

______________________________ SEX: ☐ Male ☐ Female

______________________________ SOCIAL SECURITY # ________________

______________________________ Height: ________ Weight: ________

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED

PATIENT EMPLOYER: ______________________________ PHONE #: ____________________

NEXT OF KIN: ____________________ RELATIONSHIP ________ PHONE #: ________

PRESCRIBING PHYSICIAN: ____________________ PHONE #: ____________________

DIAGNOSIS: ______________________________ DATE OF INJURY/SURGERY: ________

**INSURANCE INFORMATION**

☐ SELF PAY ☐ MEDICARE ☐ MEDICAID ☐ PRIVATE ☐ WORKMEN'S COMP ☐ VOC REHAB ☐ LAWSUIT

INSURED'S EMPLOYER: ______________________________ PHONE #: ____________________

PRIMARY INSURANCE: ______________________________ PHONE#: ____________________

ID # ____________________ GROUP # ________________ POLICY #: ____________________

SECONDARY INSURANCE: ______________________________ PHONE#: ____________________

ID # ____________________ GROUP # ________________ POLICY #: ____________________

**HOW DID YOU HEAR ABOUT US?**

☐ Doctor's Referral ☐ Newspaper ☐ Radio ☐ TV ☐ Friend ☐ Other: ____________________

**PATIENT MEDICAL RECORDS RELEASE AUTHORIZATION**

I ______________________________ understand the below signature authorizes any holder of medical records about me to be released to ***Alpha-Omega Orthotics & Prosthetics, Inc.*** or its agents which might be needed to determine medical necessity, or receive benefits payable for any related services.

I also understand that my signature authorizes insurance benefits be made payable on my behalf to ***Alpha-Omega Orthotics & Prosthetics, Inc.*** for any services or treatment provided to me by said supplier. I also permit a copy of this authorization to be used in place of the original, and as a signature on file.

______________________________ ____________

Patient or Legal Guardian/Representative Signature Date

______________________________

Printed name of above signature

## FINANCIAL POLICY

**INSURANCE INFORMATION** IS REQUIRED AT TIME OF SERVICE. IF YOUR INSURANCE AUTHORIZES PAYMENT AND/OR PARTIAL PAYMENT, YOU WILL ONLY BE RESPONSIBLE FOR THE PORTION YOUR INSURANCE COMPANY WILL NOT PAY (USUALLY 20%).

IN THE EVENT THE INSURANCE PAYMENT FROM THE INSURANCE COMPANY IS MAILED TO YOU, AND A BALANCE IS OWED, THE CHECK MUST BE ENDORSED AND MAILED TO US. IF ANY OVERPAYMENT IS MADE TO US, WE WILL REIMBURSE YOU THE OVERPAYMENT AMOUNT.

**MEDICARE PATIENTS**: WE ACCEPT ASSIGNMENT ON MOST MEDICARE CLAIMS AND THEY WILL BE FILED DIRECTLY BY OUR OFFICE. IN MOST INSTANCES, MEDICARE REIMBUSES AT 80% OF WHAT THEY CONSIDER A REASONABLE CHARGE LESS ANY DEDUCTIBLE AND CO-INSURANCE AMOUNT. YOU WILL BE RESPONSIBLE FOR THE DEDUCTIBLE AND CO-INSURANCE AMOUNTS AT THE TIME OF DELIVERY. IN CERTAIN CASES, WE WILL BILL MEDICARE AND YOUR SUPPLEMENTAL INSURANCE DIRECTLY, BUT THIS MUST BE ARRANGED WITH THE OFFICE UPON COMPLETION OF INITIAL VISIT.

**MEDICAID PATIENTS**: A CURRENT COPY OF YOUR MEDICAID CARD MUST BE ON FILE IN ORDER TO VERIFY COVERAGE. AFTER EVALUATION, YOU WILL BE INFORMED IF THE PARTICULAR SERVICE RECOMMENDED IS COVERED BY MEDICAID.

**HMO/PPO MEMBERS:** PRIOR AUTHORIZATION MUST BE RECEIVED BEFORE WORK IS STARTED. YOUR PRESCRIPTION MUST BE FROM AN AUTHORIZED HMO/PPO PHYSICIAN FOR IT TO BE APPROVED.

**WORKMAN'S COMPENSATION PATIENTS**: WE MUST BE ABLE TO VERIFY THE CLAIM AND RECEIVE PRIOR AUTHORIZATION BEFORE WORK IS STARTED.

**PAYMENT RESPONSIBILITY:** IF YOUR PRIMARY INSURANCE WILL NOT AUTHORIZE PAYMENT, YOU WILL BE INFORMED OF THIS AND BE RESPONSIBLE FOR THE ENTIRE AMOUNT AT THE TIME OF DELIVERY UNLESS PRIOR ARRANGEMENTS ARE MADE.

ALL COPAYS WILL NEED TO BE PAID AT THE TIME OF DELIVERY, UNLESS YOU ARE ALSO COVERED BY MEDICAID, OR WORKMAN'S COMPENSATION. OUR OFFICE WILL GLADLY FILE PRIMARY BILLING FOR YOUR REIMBURSEMENT.

***I UNDERSTAND THE ABOVE STATEMENTS AND AGREE THAT IN THE EVENT OF NON-PAYMENT OF AMOUNTS OWED FOR WORK AND MATERIALS PROVIDED TO ME BY ALPHA-OMEGA ORTHOTICS AND PROSTHETICS, INC., I AM RESPONSIBLE FOR THE ENTIRE AMOUNT OF THE BILL, REGARDLESS OF WHETHER OR NOT MY INSURANCE COMPANY, OR ANY OTHER THIRD-PARTY INSURER SUCH AS MEDICARE, PAYS ANY PORTION OF THE BILL. I AGREE TO PAY ANY ATTORNEY FEES AND COURT COSTS THAT ALPHA-OMEGA ORTHOTICS AND PROSTHETICS, INC. MAY INCUR IN COLLECTING ANY SUMS OWED.*** __________

______________________________________________

Patient's or Guardian's Signature                                        Date

# PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

**I wish to be contacted in the following manner (check all that apply):**

□ Home Telephone ____________

- □ O.K. to leave message with detailed information
- □ Leave message with call-back number only

Message may be left with: (Name & Relationship)

______________________________

______________________________

______________________________

______________________________

□ Written Communication

- □ O.K. to mail to my home address
- □ O.K. to mail to my work/office address
- □ O.K. to fax to this number

□ Work Telephone ____________

- □ Leave message with call-back number only

□ Other ______________________________

______________________________

______________________________
Patient Signature

______________________________
Date

______________________________
Print Name

______________________________
Birthdate

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use of disclosure of and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

**NOTE: USES AND DISCLOSURES FOR TPO MAY BE PERMITTD WITHOUT PRIOR CONSENT IN AN EMERGENCY.**

| Date | Disclosed To Whom Address or Fax # | (1) | Description of Disclosure/Purpose of Disclosure | By Whom Disclosed | (2) | (3) |
|---|---|---|---|---|---|---|
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(1) Check here if individual is informed
(2) T-Treatment; P-Payment; O-Health Care Operations
(3) F-Fax; P-Phone; E-E-Mail; M-Mail; and O-Office

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ORTHOTICS & PROSTHETICS, INC.

**Toll Free:** 888.758.0717

## *Consent to the Use and Disclosure of Health Information for Treatment, Payment and Healthcare Operations*

I understand that as part of my healthcare, Alpha-Omega Orthotics and Prosthetics originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatments
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and procedure information to my bill
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that I have the option of receiving a copy of the *Privacy Notification* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that Alpha-Omega Orthotics and Prosthetics reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided, if I request. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations and Alpha-Omega Orthotics and Prosthetics is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that Alpha-Omega Orthotics and Prosthetics has already taken action in reliance thereon.

☐ No Restrictions

☐ I request the following restriction to the use or disclosure of my health information

_______________________________________________

_______________________________________________

_______________________________________________

| ______________________________ | ______________________________ |
|---|---|
| Signature of Patient or Legal Representative | Witness |
| ______________________________ | ______________________________ |
| Date | Notice Effective Date |

Unable to obtain consent because:

☐ True Emergency; ☐ Patient non responsive; ☐ Patient confused/disorientated;
☐ Patient has been sedated; ☐ ______________________________

This area for use by Practice personnel only

Restriction ☐ Accepted ☐ Denied

| ______________ | ______________ | ______________ |
|---|---|---|
| Signature | Title | Date |

## Acknowledgement of Receipt of Notice of Privacy Practices

I certify that I have received a copy of Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills, or in the performance of health care operations by Alpha-Omega Orthotics & Prosthetics. The Notice of Privacy Practices also describes my rights and duties of Alpha-Omega Orthotics & Prosthetics, with respect to my protected health information. The Notice of Privacy Practices is posted in the waiting area.

Alpha-Omega Orthotics & Prosthetics reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, asking for one at the time of my next appointment.

______________________________________
Signature of Patient or Personal Representative

______________________________________
Name of Patient or Personal Representative

______________________________________
Date

______________________________________
Description of Personal Representative's Authority

I also acknowledge that I have received a copy of the Medicare Supplier Standards as required by Medicare standards. The standards, in brief, describe my right and the obligations of Alpha-Omega Orthotics & Prosthetics as related to their contract with Medicare as a provider.

______________________________________

Signature of Patient or Personal Representative

______________________________________
Date