

Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
 Address: \_\_\_\_\_ Soc Sec#: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: Home \_\_\_\_\_ Work \_\_\_\_\_  
 E-mail Address \_\_\_\_\_

Primary Dr. \_\_\_\_\_ Prescribing Dr. \_\_\_\_\_ Diabetic Dr. \_\_\_\_\_  
 Condition you're here for: \_\_\_\_\_ Health Conditions: \_\_\_\_\_  
 Comments, Goals, Concerns: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Telephone: \_\_\_\_\_

Employer: \_\_\_\_\_ Responsible Party: *(if different from patient)* \_\_\_\_\_  
 Address: \_\_\_\_\_ Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Phone: Home \_\_\_\_\_  
 Contact Person: \_\_\_\_\_ Work: \_\_\_\_\_

HIPAA Compliance

**INSURANCE INFORMATION**

Primary Ins: \_\_\_\_\_ Secondary Ins: \_\_\_\_\_  
 Address: \_\_\_\_\_ Address: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Phone: \_\_\_\_\_  
 ID/Policy# \_\_\_\_\_ Group \_\_\_\_\_ ID/Policy# \_\_\_\_\_ Group \_\_\_\_\_  
 Insured: *(name on card)* \_\_\_\_\_ Insured: *(name on card)* \_\_\_\_\_  
 Notes: \_\_\_\_\_ Notes: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Benefits, Medical Information Release Authorization and Acknowledgment of Financial Responsibility:**

I request my insurance benefits, if any, be paid directly to the provider. I authorize the release of any information necessary to provide services or process claims. As the responsible party I understand that I am personally responsible for the entire amount of my claim and that insurance benefits may be limited or non-existent. I agree to notify Advance Orthotic Prosthetic Services, Inc. immediately of any change in insurance coverage or status.

**Reasonable Attorney's Fees, Collection costs:**

I Agree to pay all costs of collections including reasonable attorney's fees and cost for any outstanding balance due. I also agree to pay to Advance Orthotic Prosthetic Services, Inc. interest at the rate of one percent (1%) per month on any amount that is not paid within the terms agreed upon.

**Missed Appointments:**

An appointment is a reservation of time at your convenience. We ask that if you cannot keep your scheduled time, that you call our office to give a 24 hour notice, to allow someone else the opportunity to be treated. We charge \$25.00 for no show, no call, missed appointments. \_\_\_\_\_

initials

Signature: \_\_\_\_\_ Date: \_\_\_\_\_