A Leg To Stand On
Prosthetics And Orthotics

Patients name_____ M___F___

Date of Birth_____ Social Security_____ Email_____

Address_____

City_____State_____ZIP_____ Suite_____

Home Phone_____Work_____Cell_____

Referring Physician_____Phone Number_____

Emergency Contact_____Relationship_____

Address_____Phone Number_____

MEDICAL INFORMATION

Height_____Weight_____ Diabetic? Yes_____No_____ Shoe Size_____

Reason for visit_____

Is your problem related to an injury? _____If Yes, what kind?_____

Where is your pain?_____How long have you had your pain?_____

Is your pain worse in the morning, evening, or all day?_____

Insurance Information

Primary Insurance_____

Policy #_____Group #_____

Policy Holder's name_____DOB_____

Secondary Insurance_____

Policy #_____Group #_____

Policy Holder's name_____DOB_____

I authorize the release of any medical information necessary to process claims and request payment of benefits to ***A Leg to Stand On Prosthetics & Orthotics, LLC.*** *I understand that I will be responsible for my remaining balance not covered by my insurance.*

Please give the receptionist SS card, ID, and insurance card.

Signature_____**Date**_____

1111 Griffin Ave Ste 1A Eastman ,Ga 31023

(P) 478-559-3097 (F) 478-559-3099 www.alegtostandonpo.com

A Leg To Stand On
Prosthetics And Orthotics

Name_____Date of Birth_____ M___F___

Social Security_____-_____-_____ Email_____

Address_____City_____State_____ZIP_____

Primary Phone_____Cell_____

Primary Care Physician_____City_____Phone Number_____

Emergency Contact_____Phone Number_____

Assistive Device (circle one) none cane walker rolling walker other_____

Living Situation: Home Nursing Facility_____

MEDICAL INFORMATION

Height_____Weight_____ Diabetic? YES NO Shoe Size_____

Date of amputation_____Injury date_____Above or below?_____

Cause of amputation_____Right or Left?_____

What were your activities prior to amputation?_____

What are your goals? Short term and long term?_____

_____

Insurance Information

Primary Insurance_____

Policy #_____Group #_____

Policy Holder's name_____DOB_____

Secondary Insurance_____

Policy #_____Group #_____

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Robert Carey,CP LP

1111 Griffin Ave Ste 1A
Eastman, Ga 31023
Tel:478-559-3097
Fax:478-559-3099

PATIENT HIPAA ACKNOWLEDGEMENT AND CONSENT FORM

We at A Leg to Stand On Prosthetics and Orthotics, LLC. (the "Practice") are providing this Acknowledgement and Consent Form ("Consent") to you in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which provides guidelines to healthcare providers and other parties on safely sharing and protecting patient health information. By signing this Consent, you acknowledge that you understand its contents and you consent to our collection of your personal information, including individually identifiable health information (protected health information or "PHI").

Use & Disclosure

Signing this consent also represents your consent to our use and disclosure of your private personal information including but not limited to any third-party contractors including OandPServe, LLC.

Notice of Privacy Practices

Our Notice of Privacy Practices ("Notice") provides information about how we may use and disclose your protected health information. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review the Notice before signing this Consent, and by signing you acknowledge that you had the chance to review it. The terms of our Notice may change. If we change our Notice, we may notify you that a change has been made and you can obtain a revised copy by contacting our office.

Restrictions and Revocation

You have the right to request that we restrict how PHI about you is used or disclosed. We are not required to agree to any restrictions, but if we do, we will honor that agreement. You may revoke this Consent in a signed writing, at any time, and all disclosures from that point on will cease. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent.

Protecting and Sharing Your Information

We will do our best to protect all private personal information that we receive, yet the sharing of such information with us is at your own risk. Information used or disclosed pursuant to this Consent may be redisclosed by the Practice and may no longer be protected by federal or state law.

Conditions and Application

The Practice may condition providing treatment to you upon your execution of this Consent. This Consent applies to any services the Practice provides or any interactions you have with us.
This Consent is signed by:
Patient or Representative: _____

Relationship to Patient (if other than patient): _____ Date:_____

Robert Carey,CP LP

1111 Griffin Ave Ste 1A
Eastman, Ga 31023
Tel:478-559-3097
Fax:478-559-3099

Dear Patient:

In compliance with HIPAA regulations, Robert Carey, CP LP, LLC. is committed to protecting your private health information. We need to know the names of the people that you will allow us to discuss your medical information, if any.

Please list below the names of the people that you will allow A Leg To Stand On Prosthetics and Orthotics, LLC staff and providers to talk about your health and medical information, and then at the bottom write your name and sign to give us permission to do so.

Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number

Patient Signature _____ Date _____

Patient Printed Name _____ Date _____

A Leg to Stand On Prosthetics and Orthotics LLC
1111 Griffin Ave, Ste 1A Eastman, GA 31023
P:478-559-3097 F:478-559-3099

Medical Records Release Form

Patients name_____

Address_____

Date of Birth_____

By signing this form, I voluntarily authorize

Physician Name_____

Physician Address_____

Physician Phone Number_____

to release all my medical records via FAX to A Leg to Stand On Prosthetics and Orthotics in Eastman, Georgia 31023

This authorization will remain in effect until my death or the day I withdraw my permission.

FAX:478-559-3099

Phone:478-559-3097

Signed_____**Date**_____

A Leg To Stand On Prosthetics And Orthotics

Financial Responsibility Notice

A Leg To Stand On Prosthetics and Orthotics will verify your insurance benefits and bill your insurance company as a courtesy; however verification of benefits is not a guarantee of payment.

Upon verification of benefits, you will be made aware of your benefits as quoted from your insurance company, and given an estimated amount that you will need to pay prior to, or upon delivery of your device.

If this amount is more than your deductible and/or coinsurance responsibility, you will be refunded any amounts overpaid after your claim is processed by your insurance company.

If the amount you have paid is less than your deductible and/or coinsurance responsibility, you will be billed for the additional amount after your claim is processed by your insurance company.

In certain cases, the payment is sent directly to you instead of A Leg To Stand On Prosthetics and Orthotics. If this occurs, it needs to be sent to us immediately so we can credit your account.

I have read the above Financial Responsibility Notice for A Leg To Stand On Prosthetics and Orthotics. I understand the financial process described in this notice and my signature indicates that I am in agreement with the terms listed above.

_____

Printed name of Patient/Guarantor

_____ _____

Signature of Patient/Guarantor *Date*

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