Saunders Prosthetics & Orthotics Group, LLC

Patient Information

Name: _____ Date of Birth: _____ Sex: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Social Security Number: _____ Marital Status: _____

Permanent Address: _____

City: _____ State: _____ Zip Code: _____

Medical Information

Type of Injury or Illness: _____ Date of Accident/Injury/Illness: _____

Primary Care Physician: _____ Referring Physician: _____

Insurance Information

Primary Insurance: _____ ID/Policy Number: _____

Address: _____ Phone: _____

Secondary Insurance: _____ ID/Policy Number: _____

Address: _____ Phone: _____

Authorization for Treatment

I hereby authorize treatment by Saunders Prosthetics & Orthotics Group, LLC as prescribed by my physician and/or requested by me. I also authorize the release of any medical or other information necessary to process a claim. I request payment of government or insurance benefits to Saunders Prosthetics & Orthotics Group, LLC for services rendered. I agree to be responsible for the full amount of the charges from the date of delivery if my private insurance does not pay in a timely manner or my physician fails to provide information necessary for payment in thirty (30) days. I hereby authorize Saunders Prosthetics & Orthotics to act as my agent and to accept assignment of all of my insurance benefits to be paid for the services provided. I further agree to be responsible for any fees arising from collection actions and interest on unpaid balances at the maximum rate allowable by law.

_____

Signature of Patient or Personal Representative **Date**

If signed by a Personal Representative, the follow information must also be included:

_____

Name of Personal Representative and description of their authority to act on behalf of the patient and the representative's address.

Saunders Prosthetics & Orthotics Group, LLC

Patient Approved Methods of Contact

Saunders Prosthetics & Orthotics Group would like to welcome you to our practice. We make every effort to protect the confidential nature of your medical information and care.

In order to better serve you and protect your information, we would like to know how you would like us to contact us and with whom we may discuss your care. Additional instructions or information may be written in the space provided.

Please check the box of persons that we may discuss your care with:

□ Spouse □ Siblings □ Parents/Grandparents □ Children □ Friends

□ Other:_____

May we contact you by telephone? □ Yes □ No Cell Phone? □ Yes □ No

May we contact you at work? □ Yes □ No

Please list any person we may communicate with concerning your care or in an attempt to reach you that is not listed above.

_____

_____

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_____

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Saunders Prosthetics & Orthotics Group, LLC

History of Previous Orthotics and/or Prosthetic Treatment

Medicare, Medicaid, and private insurance companies have strict guidelines on the quantity and frequency of devices or items a beneficiary may receive within a given time period. For Saunders Prosthetics & Orthotics Group to accept assignment for providing these services, we are going to base that decision in part, on your completion of this form.

I am not currently a patient in a skilled nursing facility. I have be provided with the following prosthetic, orthotic, pedorthic, and/or mastectomy services in the last 5 years.

Please provide the dates these services were provided, the description of the services provided, where they were provided, and who provided the services. If you have not had prior treatment please write NONE. If needed, extra sheets of paper will be provided on request.

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The information provided on this form is full and complete and I understand Saunders Prosthetics & Orthotics will use this information in the decision to accept assignment of benefits from my insurer. I agree to accept responsibility for payment due to my failure to fully disclose prior treatment.

_____

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Saunders Prosthetics & Orthotics Group, LLC

Financial Responsibility Statement

We are committed to providing you with the best possible care. If you have medical insurance, we are eager to help you receive the maximum allowable benefits from your plan for the services provided. In order to achieve these goals we need your assistance and your understanding of our payment policy.

Medical insurance is a contract between you and your insurance company. We will submit the necessary information to your plan in and attempt to obtain prior authorization for any services provided we know requires prior authorization under your plan. The information provided us by your insurance company is **NEVER** a guarantee of payment or benefit levels. We often find the information provided is incorrect and the benefit levels are not truly examined by your insurance company until they process a claim for payment.

Please understand that Medicare, Medicaid, and insurance carriers may not fully cover our services. They may deem the services we provide and prescribed by your physician as not medically necessary even when you and your physician feel the services are necessary. They may also limit the quantity of services they cover within a given period of time. The information you provide us concerning your prior treatment history is important, as any omissions or false information may lead us to provide services that would not otherwise be covered. You are responsible for payment of all services provided even when your insurance company says your are not responsible if it is a result of failing to provide an accurate and complete prior treatment history.

Not all services are covered benefits in all plans. Some insurance companies select certain services they will not cover regardless of our participation with your plan. Payment for any non-covered services will be the patient's responsibility.

If a service provided is not a covered benefit for your plan or if the professional fee exceeds the insurance payment for a covered benefit, I understand that I am responsible for the balance.

If any balance is not paid when due, I agree to pay all costs of collections, including reasonable attorney fees, and court costs as well as interest charges, at the maximum rate allowable by law, on the unpaid balance.

Payment is due when services are rendered. Deposits are required when custom items are ordered and there is an anticipated patient responsibility. Payment plans may be available and requests for such are handled on an individual basis.

I have read and understand this financial statement and realize that payment for all fees, regardless of insurance coverage, is ultimately my responsibility.

_____

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We emphasize that as a health care provider, our relationship is with you, our patient, and not your insurance company. We cannot be responsible for the uncovered benefits of your plan. It is your responsibility to know your policy. If you have any questions concerning the above information, please do not hesitate to ask. We are here to help you.

Saunders Prosthetics & Orthotics Group, LLC

Acknowledgement of Receipt of Notice of Privacy Practices

I certify that I have received a copy of the Saunders Prosthetics & Orthotics Group, LLC's Notice of Privacy Practices, version 080414. The notice of Privacy Practices describes the type of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills, or in the performance of Saunders Prosthetics & Orthotics Group, LLC's health care operations. The Notice of Privacy Practices also describes my rights and Saunders Prosthetics & Orthotics Group, LLC's duties with respect to my protected health information. The Notice of Privacy Practices is available at each location on request. Saunders Prosthetics & Orthotics Group, LLC reserves the right to change and/or amend the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by sending a written request to the office, asking for one at the time of my next appointment, or by accessing the Saunders Prosthetics & Orthotics Group website at www.saunderspando.com.

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