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: _____

Employment Status: _____ Driver License Number: _____

E Mail Address: _____

Permanent Address: _____

City: _____ State: _____ Zip Code: _____

How Did You Hear About Us? _____

Insurance Information

Primary Insurance: _____ ID/Policy Number: _____

Address: _____ Phone: _____

Secondary Insurance: _____ ID/Policy Number: _____

Address: _____ Phone: _____

Insured Name: _____ Date of Birth: _____

Insured Social Security Number: _____ Gender: _____

Employer Name: _____ Phone: _____

Authorization – Assignment of Benefits

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 be paid 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 insurance does not pay in a timely manner or if my physician fails to provide information necessary for payment. 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

Treatment History

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

Primary Care Physician:_____ Referring Physician:_____

Is this work related? YES NO Is this related to an auto accident? YES NO

Allergies to Materials:_____

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.

Please list all prosthetic, orthotic, pedorthic, and/or mastectomy services received 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.

_____

_____

_____

_____

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.

_____

Signature of Patient or Personal Representative **Date**

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

_____

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