**Northern Brace/Northern Prosthetics**

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Patient Information Form**

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Initial: \_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_

Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_

Male/Female Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spouse’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent/Guardian/Responsible Party (Primary Insurance Holder)**

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: Spouse/Dependant/Other Please Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_

Male/Female Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Information**

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Injury: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Latex Allergy: Yes/ No

How/Where did injury occur: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Referring Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you Diabetic? Yes/No Physician Managing Diabetes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If Amputation, Amputation Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Level of Amputation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Side: Right/Left

Yes/No Are you residing in a Nursing Facility Have you have a similar device in the last 5 years from any provider? Y/N

**Insurance Information**

**Primary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Secondary:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group#:\_\_\_\_\_\_\_\_\_\_\_\_ ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group#:\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_ Policy Holder:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_

**Worker’s Compensation/Auto Accident Insurance (if applicable)**

Insurance Company Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Claim Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Adjuster’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_

**Please note most worker’s comp./Auto insurances require us to receive authorization prior to services.**

*Please Initial Below*

\_\_\_\_\_ Northern Brace/Northern Prosthetics can call my home and leave a message regarding future appointments. (Via

answering machine, or personal message)

\_\_\_\_\_ Northern Brace/Northern Prosthetics can communicate my treatment plan and condition to my family members or

or friends. It there is anyone that you would prefer us not to talk to please list them below.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Acknowledgement**

As a part of the admission process, you will be receiving information on several policies and procedures that we have implemented

to ensure your treatment while in our care is of the highest quality. This acknowledgement indicates your receipt of such information at the time of your initial registration or patient contact.

\***Patient Bill of Rights-** This details your rights as a patient. (Posted in waiting room)

\***Warranty Policy-** Describes Northern Brace/Northern Prosthetics with respect to warranty period and repairs/adjustments.

\***Payments and Policy Agreement-** This explains our policies with respect to billing your insurance and collecting fees.

\***Patient Complaint Process-** This notifies you of our complaint and resolution process.

\***Medicare Supplier Standards-** Outlines Standards that are to be maintained by Northern Brace/Northern Prosthetics to provide

requested orthotics and prosthetic services. (Posted in waiting room)

\***Consent to treat-** I hereby authorize Northern Brace/Northern Prosthetics to provide requested orthotics and or prosthetic

services.

\***Notice of Privacy Practices-** These are located on the front counter. If there are not any on the counter, please let someone know

and you will be provided with one.

**Signature on File-** By signing below, I authorize the use of my signature on all insurance submissions, and the release of information to all insurance carriers. I am responsible for the bill and agree to pay the whole or any portion of the bill that is not covered by insurance immediately upon disapproval. Northern Brace/Northern Prosthetics can act as my agent in helping obtain payment from my insurance carriers, and payment will be authorized directly to Northern Brace/Northern Prosthetics. I also allow a copy of my signature to be used in place of the original.

I, the undersigned, have received, read and understand these polices and agreements, and hereby consent to the above as indicated by my signature. I also attest that the above questions have been answered truthfully and to the best of my knowledge.

**Signature of Responsible Party: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Benefit/Authorization to Release Information***

**Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I request the payment of authorized insurance benefits be made to either to me or on my behalf to Northern Brace/Northern Prosthetics for any services furnished to me by that supplier. I authorize any holder of medical information about me to release HCFA, Champus, and its agents, or to any private health company any information needed to determine these benefits payable for related services. I further certify that the information provided by me is true, accurate and complete.

If this is an assigned claim, or private health insurance claim, I further agree to be responsible for the full amount of the charges from the fate of delivery, if my insurance company does not pay for the charges in a timely manner, or if my physician or I fail to provide the information necessary to file the claim within thirty (30) days.

Infrequent or non-use of a prosthesis or orthosis does not absolve the patient/guardian/or responsible party from the responsibility for full payment of the prescribed or requested professional services rendered. I understand that this prescribed prosthetic or orthotic device is not returnable.

\*P**lease note:** Most insurance companies require a copy of the prescription and/or letter of medical necessity, we will request these from your doctor’s office. Without this they may deny the claim.

**Signature of Responsible Party**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For those with Medicare and Medicaid Only**

I request that payment of authorized Medicare/Medicaid benefits be made to Northern Brace/Northern Prosthetics on my behalf for any services furnished to me by Northern Brace/Northern Prosthetics unless they elect not to accept assignment for my services in which case I request payment to come to me. I authorize anyone who holds medical or other information about me to release that information to the Centers of Medicare and Medicaid services and its agents in order to determine these benefits for related services. **Please Initial: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**