Maine Orthotic & Prosthetic Rehab Services, Inc 300 Park Avenue Portland ME 04102

PATIENT INFORMATION FORM

Patient Name:____Today's Date____________________

SSN:____________________ Date of Birth:______________Email: ____________________________________

Mailing Address:____ City______________State:_____Zip:______

Street Address:____ City:_____________ State:____ Zip:______

Home Tel #:___________________ Work Tel #:____________________Cell Phone#:_______________________

Authorization: ____is ___ is not granted to leave a message(s) at the above phone numbers.

Gender: Male / Female Marital Status: Single / Married / Other

Patient's Employer:____Tel #____________________

Parent / Guardian / Responsible Party: Name (Last, First, MI) ______________________________________

Relationship to Patient: Spouse / Parent / Guardian / Other (Explain) ______________________________

Address: ____Date of Birth: _______________

How did you hear about us? (Please circle) Physician Therapist Television Website/Internet Yellow Pages

Primary Care Physician:______________________________ Referring Physician:_____________________
Emergency Contact Name:____ Relationship:_______________
Cell Phone# _________________Home Tel #:_____________________ Work Tel #:______________________

Insurance Information

Primary Insurance: ____
Mailing Address:____State:_____Zip:______
Policyholder: ____ ID #: _____________________________
Policyholder DOB: _____________________________GROUP#:____

Secondary Insurance:____
Mailing Address:____State:_____Zip:______
Policyholder: ____
Policyholder DOB: _____________________________GROUP#:____

Assignment of Benefits

I authorize my insurance company to pay benefits directly to Maine Orthotics & Prosthetics. I understand my insurance company may not pay for services that are not a covered benefit or are not considered medically necessary. I also understand that there may be benefit limitations with no-fault carriers as deductibles and benefit maximums may apply. I agree to be financially responsible for all services provided by Maine Orthotics & Prosthetics. Any existing balance beyond 90 days from the date of service (unless other arrangements have been made) can be subject to collections procedures and I will be responsible for any charges incurred by the collection agency.

HIPPA

Notice of Privacy Practices: You have a right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of our protected health information, and of other important matters about your protected health information. We encourage you to read it carefully and completely before signing this Consent.
Purpose of Consent: By signing this form, you will consent for Maine Orthotics & Prosthetics to use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Medicare Supplier Standards

"The products and/or services provided to you by Maine Orthotics & Prosthetics are subject to the supplier standards contained in the Federal regulations shown at 42 Code of Federal Regulations Section 424.57(c). These standards concern business professional and operational matters (e.g., honoring warranties and hours of operation). The full text of these standards can be obtained at http://ecfr.gpoaccess.gov. Upon request we will furnish you a written copy of the standards."

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Patient or Authorized Representative Signature Date