CREATIVE TECHNOLOGY OPS

PATIENT INFORMATION FORM

PATIENT INFORMATION

Legal Name: Last: _____ First: _____ MI: ____

Nickname: _____

Date of Birth: _____ ◯ Male ◯ Female Social Security No.:

Email Address: _____

Occupation: _____ Marital Status (circle one): ◯ Single ◯ Married ◯ Divorced

Home Phone: _____ Cell Phone: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Phone Number: _____

☐ ***PARENT OR GUARANTOR INFORMATION (If patient is under the age of 18)***

Guarantor Legal Name: Last: _____ First: _____

Home Phone: _____ Cell Phone: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Patient's Relationship to Guarantor (circle one): ◯ Child ◯ Legal Guardian

INSURANCE INFORMATION (If you are not the primary holder)

Primary Insurance Company: _____

Primary Insured's Name: _____ Relationship: _____

Insured's SS#: _____ Insured's Date of Birth: _____

AUTO INSURANCE OR WORKERS COMP INFOROMATION (If applicable)

Insurance Company: _____

Claim Manager: _____ Phone Number: _____

Date of Injury: _____ Claim Number: _____

PLEASE READ BACK THEN SIGN AND DATE – THANK YOU

CREATIVE TECHNOLOGY OPS

PATIENT INFORMATION FORM

Orthotic Prosthetic Solutions is a partnership of board certified practitioners. OPS takes pride in providing quality orthotic and prosthetic devices. Our warranty period for custom orthotics and prosthetics on workmanship and materials is 3 months from the day you take the device home. OPS cannot be responsible for physiological, pathological, or anatomical changes in a patient's medical condition, although we will attempt to maintain proper fit during this period. At the discretion of the practitioner, normal adjustments will be made for a period of one year. Any additions prescribed by a physician will have an additional charge. Adjustments, repairs, or need of replacement incurred as a result of excessive wear, i.e. sports, certain work activities, will have an additional charge. A physician has prescribed custom orthotics and prosthetics. Custom, means it is made to fit specifically for your body. **They cannot be returned for credit or refund.** Off-the-shelf items cannot be returned for hygienic reasons. **If you are having any difficulty with the fit of your device, please be sure to call the office and we will get you in as soon as possible for adjustment.**

PAYMENT POLICY

OPS will make every effort to verify your benefits and bill your insurance. **Ultimately it is your responsibility to know your benefits. It is always a good idea to call your insurance and check your benefits yourself.** Insurance companies have a disclaimer that the statement of benefits is **not a guarantee of payment.** This means that you may have benefits, but the insurance may not pay for the device if they deem it not medically necessary. If after processing the claim, they decide to not pay OPS, OPS will be billing you. **Deductibles and co-payments are your responsibility, and OPS will collect this from you at the time of delivery of the device.**

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

I certify that I have reviewed a copy of Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills, or in the performance of OPS health care operations. The Notice of Privacy Practices also describes my rights and OPS's duties with respect to my protected health information. OPS reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, or asking for one at the time of my next appointment.

ASSINMENT OF BENEFITS

I hereby authorize Orthotic Prosthetic Solutions to release necessary medical information to my insurance to process my medical claim. I authorize my insurance carrier to pay benefits directly to Orthotic Prosthetic Solutions on my behalf for any services furnished me by Orthotic Prosthetic Solutions. I authorize any holder of medical or other information about me be released to the Health Care Financing Administration and its agents to determine the benefits for services provided.

I, the undersigned, have read and understand these policies and agree to all the above.

_____	_____	_____
Signature of Responsible Party	Print Name	Date

MEDICARE PATIENTS ONLY: I acknowledge that I have reviewed a copy of the Medicare Supplier Standards.

_____	_____	_____
Signature of Responsible Party	Print Name	Date

SAVE RESET PRINT EMAIL