NEW PATIENT INFORMATION FORM

Patient's Name_____DOB_____ Email_____

Height_____ Weight_____Shoe Size_____Accident/Onset Date_____

Home Ph#_____Cell Ph#_____ Other Ph#_____

Home Address:_____

City_____State_____ Zip Code_____

Mailing Address(if different)_____

City_____State_____ Zip Code_____

EMERGENCY CONTACT INFORMATION

Name_____Relationship_____

Best Daytime Ph#_____Alt#_____

Who can we thank for referring you to us?

- ☐ Yellow Pages
- ☐ Therapist
- ☐ Dr's Office
- ☐ Website
- ☐ Existing Patient

Name of Referral_____

Have you ever had an orthotic or prosthetic device before? _____

If yes, What type and when did you receive it?_____

Referring Physician_____

PrimaryPhysician_____

Are you diabetic? YES☐ NO☐Diabetic Physician_____

Primary Insurance_____ Policy Holder Name_____

Secondary insurance_____ Policy Holder Name_____

By signing below, I ackknowlege that I have received North Carolina Orthotics and Prosthetic's Patient Information Document that includes North Carolina Orthotics and Prosthetic's Consent for Treatment, Release of Medical Information and Assignment of Benefit Guidelines, the Medicare Supplier of Standards, Notice of Privacy Practices and acknowledge North Carolina Orthotics and Prosthetics Complaint protocol and After Hours policy. I acknowledge that all information that I have provided is true and accurate to the best of my knowledge.

Signature of Patient or Guardian_____ Date_____

Relationship to Patient: _____

New Patient Release Form

North Carolina Orthotics & Prosthetics, Inc is authorized to release protected health information about the below named patient to the persons indicated. The purpose is to inform the patient or others in keeping with the patient's instructions.

Name of Patient: _____Date of Birth: _____

What information may be left on answering machine/ voicemail (if applicable):

- ☐ Appointment Info
- ☐ General Message

Please list approved individuals to receive information (if you have more than one individual, please ask receptionist for another form)

Name: _____

Relationship: _____

What Information may we release to the above named individual?

- ☐ Financial/Billing
- ☐ Health Information

Patient Information:

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or request a copy of the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective from the time and date that the written request of revocation is received by NCOPI.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

THIS AUTHORIZATION SHALL BE IN EFFECT UNTIL REVOKED BY THE PATIENT.

Financial Responsibility:
Your healthcare insurance policy is a contract between you and your insurance company or employer. NCOPI will assist you to obtain payment from your healthcare insurance policy for medical services and goods that you receive at NCOPI. However, you remain primarily responsible to pay for all medical services and goods that you receive at NCOPI.

Health Insurance does NOT cover all medical goods and services.
I understand that there are many types of healthcare insurances and that each provides coverage for different medical goods and services. If the healthcare insurance denies payment of my claim because it is not a covered service or good, I am responsible for all charges.

I am responsible to provide accurate insurance information. I am responsible to provide NCOPI with all current insurance information and contact information, including any secondary insurance. If the claims are denied due to untimely filing because I have not provided current insurance information, I am responsible for all charges. In the event that I have more than one coverage and there are issues associated with the coordination of benefits, it is my responsibility to contact the insurance carrier to have any issues resolved.

I am responsible for prompt payment: Payment in full is due within 75 days from the date of service. For alternative payment arrangements or for any other questions regarding insurance coverage, contact our office at (252) 436-2611.

I understand and agree with the above:

Signature of Patient/Guardian _____ Date:_____

North Carolina Orthotics and Prosthetics

Consent for Treatment
Release of Medical Information
Assignment of Benefits

Consent for Treatment: I, the undersigned, herby voluntarily consent to the examination and treatment prescribed by my physician(s) and/or therapist and rendered by the professional and support staff of North Carolina Orthotics & Prosthetics. I understand that I have the right and the responsibility to participate in the development of my plan of care.

Release of Medical Records: i authorize any holder of medical or other information about me to release such information as may be necessary for the completion of my insurance claims and for continuing medical care to North Carolina Orthotics & Prosthetics. A photocopy of this authorization form is to be considered valid. i also consent to the release of my medical and private health information by North Carolina Orthotics & Prosthetics for use as described in the Notice of Privacy Practices

Assignment of Insurance Benefits: I hereby authorize direct payment to North Carolina Orthotics & Prosthetics for my insurance benefits herein specified and otherwise payable to me. I also hereby authorize automated claims to be submitted electronically to Medicare/Medicaid on my behalf.

It is necessary for the patient or representative to give complete an accurate insurance information. If the information is incomplete or inaccurate, we will not be able to appropriately bill the insurance company and the responsibility for payment then becomes that of the patient.

Insurance payments are usually received within 30-60 days from the time of billing. If a patient's insurance has not made payment to our office within 90 days, we may request the patient to pay the balance due, and then seek reimbursement from the insurance company when and if it pays.

Our office does not guarantee that the patient's insurance company will pay for the services rendered. We will perform our routine insurance billing procedures upon verification of coverage. However, if for some reason the patient's insurance claim is denied, the patient is then considered to be responsible for charges not covered by this assignment. The undersigned further agrees to pay all costs of collection of any such balance including attorney's fees.

For Medicare Recipients Only: I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration, Intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I also authorize the Social Security Administrative Dept. to furnish any benefits information regarding my Medicare eligibility to North Carolina Orthotics & Prosthetics. *Medicare will only pay for services that are determined to be "reasonable and necessary" under section 1862 (a)(i) of the Medicare law.*

Signature of Patient or Representative_____Date_____

(authority)

Printed Name of Patient or Representative_____

(authority)

North Carolina Orthotics and Prosthetics

Acknowledgement of Receipt of Notice of Privacy Practices

Notice of Privacy Practices: My signature below acknowledges receipt of the Notice of Privacy Practices, which 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 North Carolina Orthotics & Prosthetics health care operations. The Notice of Privacy Practices also describes my right and North Carolina Orthotics & Prosthetics duties with respect to my protected health information. The Notice of Privacy Practices is posted in the patient waiting room. North Carolina Orthotics & Prosthetics reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised copy by calling the office and requesting a revised copy be sent in the mail.

Signature of Patient or Representative_____ Date_____
(authority)

Printed Name of Patient or Representative (relationship to patient) _____
(authority)

North Carolina Orthotics and Prosthetics

Medication List

Please list current medications

Medication **Dosage**

This list of medications is correct to the best of my knowledge at the time of completion.

Signature of Patient or Representative_____Date_____

(authority)

Printed Name of Patient or Representative_____

(authority)

Submit: Raleigh | Submit: Rocky Mount | Submit: Roanoke | Submit: Goldsboro | Submit: Henderson