

+American Limb & Orthopedic Company
PATIENT INFORMATION

PATIENT'S NAME: _____
ADDRESS: _____
CITY: _____ **STATE:** _____ **ZIP CODE:** _____
TELEPHONE:() _____ **S.S.#:** _____
DATE OF BIRTH: _____
MARITAL STATUS: _____ **SPOUSE'S NAME:** _____
EMPLOYER: _____ **TELEPHONE:** _____

REFERRING PHYSICIAN: _____ **PHONE:** _____
DIAGNOSIS: _____
FAMILY PHYSICIAN: _____
ARE YOU DIABETIC: (PLEASE CHECK) _____ **YES** _____ **NO**
DIABETIC PHYSICIAN: _____

If the patient is a child or dependent, please complete this section:

NAME OF RESPONSIBLE PARTY: _____
RELATION: _____ **DATE OF BIRTH:** _____
ADDRESS (if different from patient): _____
TELEPHONE: _____ **S.S.#:** _____
EMPLOYER: _____ **TELEPHONE:** _____

INSURANCE INFORMATION

PRIMARY: _____ **SECONDARY:** _____
ADDRESS: _____ **ADDRESS:** _____

TELEPHONE: _____ **TELEPHONE:** _____
GROUP#: _____ **GROUP#:** _____
MEDICARE#: _____
MEDICAID#: _____

WORK COMP INFORMATION

CONACT PERSON: _____
ADDRESS: _____
TELEPHONE: _____

American Limb & Orthopedic Company
RELEASE/CONSENT FORM

This release/consent form must be completed in order for the American Limb & Orthopedic Company to bill your insurance company and for you to understand your financial responsibility.

Please read the following carefully and sign below.

ASSIGNMENT OF BENEFITS

The patient requests that payment of authorized insurance benefits be made, on the patient's behalf, to the American Limb & Orthopedic Company for the orthotics or prosthetic services rendered. The patient understands that their signature (below) authorizes payment by the insurance carrier to be made directly to the American Limb & Orthopedic Company.

MEDICAL INFORMATION RELEASE

The patient authorizes any holder of medical information, regarding the patient, which is needed for clinical purposes or for the determination of benefits, or benefits payable, for related services be released to the American Limb & Orthopedic Company. The patient understands that their signature (below) authorizes the release of this medical information.

FINANCIAL RESPONSIBILITY CONSENT

The patient agrees to assume financial responsibility for any claim or portion of claim thereof, due to the American Limb & Orthopedic Company for services rendered, and not covered by the insurance policy. If the insurance company denies coverage for a product, the patient will assume financial responsibility for its payment. The patient acknowledges the responsibility for any payment not received from the insurance carrier within sixty (60) days from the date of service.

PATIENT'S NAME: _____ DATE: _____

PARENT, GUARDIAN OR AUTHORIZED NAME: _____

RELATIONSHIP TO PATIENT: _____

ADDRESS: _____

STATE: _____ ZIP: _____ PHONE: _____

SIGNATURE OF PATIENT, PARENT, GUARDIAN, OR AUTHORIZED

CC: PATIENT

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I certify that I have received a copy of ALOC'S 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 ALOC'S health care operations. The Notice of Privacy Practices also describes my rights and ALOC'S duties with respect to my protected health information. The Notice of Privacy Practices is posted in the front office. ALOC 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. You may also access ALOC'S web site, www.americanlimb.com to obtain a copy.

Signature of Patient or Personal Representative

Name of Patient or Personal Representative

Date

Description of Personal Representative's Authority