PATIENT INFORMATION FORM

Please print all information

Today's Date_____

Patient Name:_____SSN:_____

Home Address:_____City:_____

State:_____Zip:_____-_____Home Phone:_____

Work Phone:_____Cell Phone:_____

Date of Birth:_____Sex: Male / Female Marital Status: S / M / D / W

Email:_____

Employed by:_____

Employers Address:_____

Spouse's Name:_____Date of birth:_____

Spouse's phone#_____Spouse's SSN:_____

Responsible Party/Guarantor **(if different from patient)**_____

Address_____City_____State_____Zip_____

Phone _____Cell_____Work_____

SSN_____Date of Birth_____

Employed by_____

INSURANCE

Primary Insurance_____Secondary Ins_____

Insured_____DOB_____Insured_____DOB_____

ID#_____SS#_____ID#_____SS#_____

HOW DID YOU HEAR ABOUT US

_____Physician _____Hospital_____Physical Therapist_____Newspaper_____Friend

_____Insurance Company_____Nurse_____VA_____Advertising_____Other

REFERRING PHYSICIAN INFORMATION

Referring Physician_____Phone:_____

Primary care Physician_____Phone:_____

NAME OF CLOSEST RELATIVE NOT LIVING WITH YOU

Name_____Relation_____phone_____

Name_____Relation_____phone_____

MEDICAL HISTORY

1. Is your condition a result of an accident from employment? Yes or No
2. Is your condition a result of an auto accident? Yes or No
3. Is your condition a result of any other type of accident? Yes or No
4. Is your condition congenital(from birth)? Yes or No

Date of Accident/Injury:_____State Accident Occurred:_____Date of Amputation:_____
Type of Accident:_____
Is this a Worker's Comp Claim? Y / N (if so please present a card)
BWC#_____MCO Name_____

General Health: _____Excellent_____Good_____Fair_____Poor

Height _____Weight_____ any recent changes in weight? If yes, how much_____

Have you had or do you have any of the following ?

_____Heart problems_____Hepatitis Aor B_____Hepatitis C_____Hypertension_____HIV

_____Parkinson Disease_____Multiple sclerosis_____ALS_____Seizure Disorder_____MRSA

_____Vascular Disease_____Alzheimer Disease_____Hearing Loss_____Vision Problems____Stroke

_____Diabetes_____Kidney Disease_____Obesity_____Alcoholism_____Pregnant_____Allergies

_____Osteoporosis_____Scoliosis_____Kyphosis_____Osteoarthritis_____Rheumatoid Arthritis

_____Drop Foot_____Fractures_____Amputations_____Pulmonary Disease_____TB___Latex

List any other conditions that you feel might affect your treatment including dates and descriptions of surgeries:

_____

_____

List any medications you are currently taking:

_____

_____

Please list any hobbies or activities that you are involved in now and prior to your injury:_____

_____

Please list any goals you may have once you receive your Orthosis or Prosthesis:_____

_____

Please list any like or similar devices you may have had in the last 5 years:_____

_____

Yes or No Have you received a like or similar device in the last 5 years?
Yes or No Are you currently residing in a nursing home?
Yes or No Do you have surgery scheduled to treat the condition for which this device will be used?
Yes or No Were you offered a copy of the private practices HIPPA?

PATIENT SERVICE AGREEMENT

1. The time we spend with our clients is important in order to provide the highest quality of service. Please be patient, you will receive the same courtesy and confidentiality while we are serving you.
2. In order to better serve you and in partnership with your Physician, Lima Brace & Limb, Inc requests the you present to us the prescription from you physician at the time of service.
3. In addition to the prescription all insurance cards if applicable must be presented. We will verify all information with your insurance company. Some insurances require pre-authorization and/or referral forms. Lima Brace & Limb, Inc will make every effort to expedite the process, but at times obtaining the authorization may be a lengthy process.
4. Any "self pay" responsibilities are due at time of the service, or payment plan set up.
5. You will be properly and thoroughly instructed in the use of all products and services provided.
6. **Merchandise returns and nonrefundable items:** Merchandise that has come in direct contact with the skin and **all custom order products are NOT returnable.** For special order products that are not worn, a 15% restocking fee will be charged if returned. If returned, merchandise must be returned within 15 days in its original condition and box.
7. Depending on the level of the service provided, a follow-up visit will be scheduled. Your practitioner will schedule an appointment date and time if applicable.
8. In our continuous effort to improve or services, you are encouraged to complete a customer satisfaction survey. Your feedback is instrumental for improving organizational performance.
9. Lima Brace & Limb, Inc supports open communication with our patients. Please feel free to contact us regarding care, services, or payment policies.

PATIENT ACKNOWLEDGMENT

As a part of the admission process, you will be receiving information on several policies and procedures to ensure your treatment is of the highest quality. This acknowledgment 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**
- **Warranty Policy- Describes Lima Brace & Limb, Inc policies with respect to warranty period and repairs/adjustments.**
- **Payment and Policy Agreement- This explains Lima Brace & Limb, Inc's policies with respect to billing your insurance and collecting applicable co-pays and deductibles .**
- **Urgent Care- Informs you of our urgent care procedures**
- **Patient Complaint Process- This notifies you of our complaint and resolution process.**
- **Medicare Supplier Standards-Outlines standards that are to be maintained by Lima Brace & Limb, Inc as a Medicare provider.**
- **Consent to Treat- I hereby authorize Lima Brace & Limb, Inc to provide requested Orthotic/Prosthetic services.**
- **Assignment of Benefits- I hereby authorize Limb Brace & Limb, Inc to release necessary medical information to my insurance carrier(s)to process my medical claim. I also authorize my insurance carrier to pay benefits directly to Lima Brace & Limb, Inc.**

Assignment of Benefits: I request that payment of authorized Medicare, Medicaid, or private insurance benefits be made to **Lima Brace & Limb, Inc** for any covered services furnished to me by Lima Brace & Limb, Inc. If my insurance carrier pays me directly, I agree to forward all funds to Lima Brace & Limb, Inc within ten(10) working days. Under some plans, including Medicare, I understand some of the services I may receive may NOT be covered. I agree I am responsible for paying all non-covered amounts unless otherwise provided by law, regulation or Lima Brace & Limb, Inc contractual relationships. I agree to be responsible for the full amount of the charges from the date of delivery, if my third-party payer does not pay for the charges in a timely manner, or if my physician or I fail to provide the necessary information to submit the claim for payment. I authorize anyone who holds medical information about me to release that information to the Centers for Medicare and Medicaid Services, its agents and other private insurances in order to determine these benefits or benefits for related services.

I, _____ am in need of an Orthosis/Prosthesis and hereby consent to Lima Brace & Limb, Inc providing the care and services attendant to my Orthotic/Prosthetic needs. I understand that the practice of Orthotics and Prosthetics is not an exact science, and that use of an Orthotic or Prosthetic device could involve risk of injury or severe bodily harm. I acknowledge that no guarantees have been made to me as to my ability to use my Orthotic or Prosthetic device once the fitting is complete.

Waiver and Release for Photography/Videotaping: If during the fitting process, photographs or videotapes are made of me, I waive all rights that I may have to any claims for payment or royalties in connection with any display, televising or publication of the pictures or video and further release Lima Brace & Limb, Inc and its directors, officers, and staff from any liability in connection with the use of such pictures and related materials.

Release of Records: I authorize Lima Brace & Limb to release to any governmental healthcare program and its agents or to any private insurance company or its agents any information needed to determine my benefits or the benefits payable for Lima Brace & Limb services. I understand further the the information authorized for release may include records which may indicate the presence of a communicable disease.

I hereby authorize my attending physician to release all medical records pertaining to my orthotic/prosthetic care to Limb Brace & Limb, Inc

I, the undersigned, have received, read and understand these policies and agreements and hereby consent to the above. I also attest that the above questions have been answered truthfully to the best of my knowledge. And I am aware that I am responsible for any services and/or charges **NOT** covered by my insurances.

_____ _____

Patient Signature(or Parent/guardian or responsible party) **Date**

Lima Brace & Limb understands that insurance and personal information change over time, please inform us of any changes that need to be made to your file at every visit. Please make sure you present your insurance cards at every appointment, so we can make sure your insurance is being billed correctly. Thank You!