Lima Brace & Limb

Patient Registration

Patient Name_____SS#_____
Address_____City_____State_____Zip_____
Home Phone_____Work #_____Cell#_____
Email Address_____
Marital Status M S D W Date of Birth_____Height_____Weight_____
Guarantor_____Relation to guarantor self___spouse___child___other___
Address_____City_____State_____Zip_____
Phone_____Guarantor DOB_____Power of Attorney Yes___No___
Referring Physician_____Phone_____
Primary Physician_____Phone_____

How did you here about us?
Physician___Hospital__Physical Therapist___Insurance Co___VA___Friend___Google___Other___
Condition Information?
Are you diabetic? Yes___No___ if yes, physician treating your diabetes:
Physician Name_____Phone_____

Have you received the same or similar device in the past 5 years? Yes____No___
Are you in hospice care? Yes___No___Do you have any surgeries scheduled? Yes___No___
Were you offered a copy of the HIPPA policy?Yes___No___If applicable did you receive the Medicare standards? Yes___No___Are you a resident of a skilled Nursing Home Facility? Yes___No___
Is your condition a result of an injury? Yes___No___If yes was it work related? Yes___No____
If yes employer name_____Address_____
City_____State_____Zip_____BWC#_____

Primary Insurance_____Phone_____
Name of Insured_____Relationship_____
DOB_____Policy#_____Group#_____
Secondary Insurance_____Phone_____
Policy#_____Group#_____

General Overall Health:
Excellent___Good___Fair___Poor___Any recent changes in weight? Yes___No___how much_____
Have you had or do you have any of the following?
Heart Problems___Vascular Disease___Pulmonary Disease___Stroke(date of stroke)_____
Drop Foot___Hepatitis AorB____Hepatitis C___Hypertension___HIV___Parkinsons___Multiple Sclerosis___ALS___Seizure Disorder___MRSA___VRE___Alzheimer___Diabetes___Kidney___
Osteoarthritis___Rheumatoid Arthritis___Osteoporosis___Scoliosis___Kyphosis___Back Pain___
Hearing Loss___Vision Problems___Fractures(location)_____Amputations_____
Please list any other conditions or medications you feel might affect your treatment including dates and descriptions of surgeries:_____

_____

_____

_____

List any hobbies or interests:_____

_____

_____

_____

Assignment of Benefits:

I request that payment of authorized Medicare, Medicaid, or private insurance benefits be made to **Lima Brace & Limb** for any covered services furnished to me by **Lima Brace & Limb**. If my insurance carrier pays me directly, I agree to forward all funds to **Lima Brace & Limb** within 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** 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 or 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 are for related services.

I authorize **Lima Brace & Limb** to release to any governmental or a healthcare program and its agents for to any private insurance company or its agents any information needed to determine my benefits for the benefits payable for **Lima Brace & Limb** services. I understand further, 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 **Lima Brace & Limb**.

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. I am aware that I am responsible for any services and/or charges not covered by my insurance.

_____ _____

Signature of Patient or Guarantor 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 that we can make sure your insurance is being billed correctly. Thank you!