OrthoPro of Reno, Inc.

SSN: ________-_______-__________

First Name:____________________ MI:____ Last Name:________________

Date of Birth:__________________ Height:__________ Weight:__________

Sex (Please Circle One): Male Female

Marital Status: (Please Circle One): Married Single Other

Home Phone:__________________ Other(Cell)Phone: ________________

Address:____

City:________________________ State:_______ Zip Code____________

Email:____

Are you employed? (Please Circle One): Yes No

Name of your employer:____________________ Work Phone:______________

Emergency Contact (Name): ____________________

Relationship to Patient:______________________

Emergency Contact Phone:____________________

Name of Physician who wrote your prescription or referred you to us today?

____

Insurance Information

Primary Insurance:____

Secondary Insurance:____

Tertiary Insurance:____

Are you the primary insured member on ALL your insurance policies?

Yes or No

If "NO", please list the following information for the primary insured person:

Name (First and Last):______________________

Date of Birth:____________________

SSN: ________-_______-__________

Employer:______________________

Relationship to Patient:____________________

Medical Questionnaire

- Do you have arthritis (of any kind)? Yes No
  *If "yes", where are you affected?:______________________________
  ____

- Do you have diabetes (Type 1, Type 2, or Pre-Diabetic)? Yes No
  *If "yes", are you taking medications for your diabetes? Yes No

- Do you have high blood pressure? Yes No
  *If "yes", are you taking medications for your high blood pressure? Yes No

- Do you have any other heart-related medical issues? Yes No
  *If "yes", please describe:______________________________
  ____

- Do you have any allergies? Yes No
  *If "yes", please list them:______________________________
  ____

History of Orthotic or Prosthetic Use

Have you ever been seen in ay other facility (like this one) for any orthotic or prosthetic services? Yes No

*If "yes", where were you seen?:______________________________
____

*What services were provided to you?:______________________________
____

*Did you have any problems or questions with your previous service? Yes No

*If "yes", is there anything we can do to help you with those problems? Yes No

*Please describe:
____
____

Is there anything else that you feel we need to know before your appointment today? Yes No

*If "yes", please list:
____
____
____
____
____

Assignment of Benefits
Nevada Insurance Disclaimer
Consent to Privacy Practices

I hereby authorize payment to OrthoPro of Reno, Inc. the benefits herein specified and otherwise payable to me for any services rendered by OrthoPro of Reno, Inc. subsequent to this date and for such other charges as may be made by OrthoPro of Reno, Inc. I hereby agree to pay the same and also agree that in the event medical coverage is sufficient to pay the indebtedness incurred and should there be any money over and above that necessary to pay the registration, I agree that
OrthoPro of Reno, Inc. may apply coverage against any amount which is owed by myself, my spouse, or legal dependents of myself or my spouse at the time to OrthoPro of Reno, Inc.

I certify that the information given by me in applying 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 or its intermediaries or carriers any information needed for this or related medical claims. I request that payment of authorized benefits be made on or in my behalf to OrthoPro of Reno, Inc. A copy shall be as valid as the original.
I, the undersigned, certify that I have read the foregoing, and that I am the patient, or duly authorized by the patient as the patient's general agent, to execute the above and accept its terms.

As the patient, I acknowledge that I am aware that a quote of insurance benefits is not a guarantee of coverage. It is recommended that you know your insurance benefits prior to receiving any services from any healthcare provider to ensure the best possible financial outcome. Authorization is also not a guarantee of payment. Actual payment will be determined when the claim is received by your insurance. By signing below, you acknowledge that you have been duly informed of the above disclaimer and that you accept financial responsibility for any and all services performed by OrthoPro of Reno, Inc.

By signing below, you consent to the use and disclosure of your PHI by OrthoPro of Reno, Inc., our staff, and our business associates for the sole purpose of treatment, payment, and healthcare operations. For a more detailed description of our uses and disclosures of PHI, please review our Notice of Privacy Practices, which is located in our waiting room. You have the right to review our Notice prior to signing this consent. The terms of this Notice may change. If the terms do change, you may obtain a revised Notice by contacting us at (775) 324-1443 and requesting a new Notice. You have the right to request that we restrict our uses or disclosures of your PHI that we are otherwise permitted to make for treatment, payment and healthcare operations, although we are not required to agree to those restrictions. However, if we do agree to further restrictions, they are binding on us. Finally, you have the right to revoke the consent in writing, except to the extent that we have acted in reliance on it.

_______________________________ Signature of Patient (or patient's representative)

_______________________________ Printed Name of Patient

_______________________________ Date

WORKERS COMPENSATION

If you have a valid Workman's Compensation Claim, we will need to obtain Approval/Prior-Authorization from your Workman's Compensation Company to provide you with the item that your Doctor has ordered.

You will be required to provide the following information if you wish us to seek Authorization and bill your Workman's Compensation Insurance for your visit:

Your Name: ______________________________ Date of Birth: ____________

Social Security #: ______________________________ Date of Injury: ___________

Employer: ____

Workman's Comp Carrier: ____

Adjusters Name: ____________________________ Claim#: ________________

Adjusters Phone: ____________________________

Workers Comp Address: ____

____

We will begin the process of obtaining Prior-Authorization as soon as your paperwork is completed. We may also have to wait for additional documentation from your physician before we can continue with your care. Please be advised that if we do not obtain Prior-Authorization by your appointment date and you choose to take your item with you, you may be responsible for all costs associated with this visit if your Workman's Compensation Company does not provide Authorization of the item and/or denies your claim.

By signing and dating below, you agree that you have read and understand the above.

I certify that the information given above is correct. I clearly understand and agree that all services rendered to me that are not covered, are charged directly to me, and that I am personally responsible for payment in the event that the item I received is denied by Workman's Compensation.

______________________________ ______________________________

Signature Printed Name

____

Date