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

Financial Policy

At OrthoPro, our first goal is to help our patients to the highest level of mobility they can achieve. We also want to help our patients understand their insurance benefits and how their financial responsibility will be implemented through the course of their treatment.

It is important that you know that before we try to collect any money from you for our services, we will first attempt to collect from whatever insurance you currently hold. It is very important that you give us up-to-date information so that we can properly process your claim with your insurance company.

We are prohibited, **by law**, from billing your insurance before you receive any services from us. We will not bill your insurance until you take delivery of your items.
We are also prohibited, **by law**, from writing off any deductible, co-pay, or co-insurance amount you have without first assessing your financial situation and attempting to resolve any outstanding debt.

Having said that, we are more than happy to work with you to make any financial arrangement that you are comfortable with to close out the balance of your account.

If we are ordering your device, or if we are custom making your device, there will be a deposit required at the end of your first visit with us of either $50 or your insurance co-payment amount, whichever is less.

If you decide after your initial appointment that you do not want to proceed with services or that you are not going to return to pick up your custom-made device, we will keep the deposit and no further charges will be issued to you. With custom-made devices, we will pursue payment from your insurance for any parts that cannot be reused.

If you decide to proceed with treatment and delivery of your ordered or custom-made device, we will apply your deposit to your balance after your insurance pays.

If your insurance pays the balance due in full on your account, we will refund your deposit to you.

If, at any time, you have any questions regarding this financial policy, your insurance benefits, or how we proceed with billing your claim, please feel free to contact our office at the number listed above or at our website, www.oandpreno.com.

By signing below, I acknowledge that I have read and understand this policy.

_____
Patient's Printed Name

_____ _____
Patient or Responsible Party Signature Date

OrthoPro of Reno, Inc.
Custom Orthotics & Prosthetics
487 Casazza Drive, Reno, NV 89502 • (775) 324-1443 • Fax (775) 324-1663

Medicare Supplier Standards

Notice to Patients

The product(s) and/or service(s) provided to you by OrthoPro of Reno, Inc. are subject to the supplier standards contained in the Federal regulations shown at 42 code of Federal Regulations Section 424.57(c). These standards concern business professional and operational matters (e.g. honoring warranties and hours of operations). The full text of these standards can be obtained at http://ecfr.gpoaccess.gov. Upon request we will furnish you a written copy of the standards.

By signing below, I am indicating that I understand that these standards are available to me as listed.

_____
Patient Signature

_____
Date