FREEDOM
PROSTHETICS & ORTHOTICS

PATIENT DEMOGRAPHICS

Name: _____

Legal First MI Last

DOB: _____ **Sex**: _____ Female _____ Male

Last 4 of Social Security Number:_____ **Pronoun(s)**: _____

Mailing Address:

_____

_____

_____

City State Zip

Preferred Contact Information:

Home #: (_____)_____

Cell # : (_____)_____

Email : _____

Please List Any Contact(s) We Are Able to Release Your Medical Information To:

_____

Name Relationship Phone Number

_____

Name Relationship Phone Number

INSURANCE

ONLY FILL THIS OUT IF YOU ARE **NOT** THE PRIMARY POLICY HOLDER

Primary Insurance: _____

Policy #: _____

Group #: _____

Policy Holder: _____

Legal First MI Last

_____

DOB Social Security

Secondary Insurance: _____

Policy #: _____

Group #: _____

Policy Holder: _____

Legal First MI Last

_____

DOB Social Security

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Medical/HIPAA Information Release

I certify that I have received a copy of Notice of Privacy Practices from Freedom Prosthetic & Orthotics, LLC. 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 Freedom Prosthetic & Orthotics, LLC health care operations. Freedom Prosthetic & Orthotics, LLC is required by law to make and keep records of my/the patient's medical treatment. Freedom Prosthetic & Orthotics safeguards those records and it uses and discloses such records and information they contain only in accordance with State and Federal Laws. Such uses and disclosures are described in detail in the Notice of Privacy. which may be amended from time to time. I reserve the right to change the privacy practices that are described in the 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.

☐ I Accept ☐ I Decline Signature: _____ Date: _____

Consent for Treatment

I hereby consent to the medical treatment, diagnostic, and other healthcare services to be provided by Freedom Prosthetic & Orthotics, LLC practitioners and other employees or contractors to me/the patient during this visit and any subsequent visits. I understand this consent may be revoked in writing at any time.

☐ I Accept ☐ I Decline Signature: _____ Date: _____

Financial Responsibility

I, the undersigned, certify that I (or any dependent) have insurance coverage & assign directly to Freedom Prosthetic & Orthotics all insurance benefits, if any. Otherwise payable to me for services rendered. I, hereby authorize Freedom Prosthetic & Orthotics to release all information necessary to secure payment benefits from my insurance. I authorize the use of this signature on all insurance submissions. I and the undersigned, if other than the patient, agree to pay for all health care services rendered to me/the patient including but not limited to any amounts not paid by an insurance company or other third party payer. I and the undersigned, if other than the patient, remain responsible for all copayments, deductibles, co-insurance, and/or non-covered services regardless of amount paid by insurance or third party payer. I and the undersigned, if other than the patient, understand and agree to pay a service charge of $20.00 for any returned check.

☐ I Accept ☐ I Decline Signature: _____ Date: _____