FREEDOM
PROSTHETICS & ORTHOTICS

PATIENT DEMOGRAPHICS

Name: ____

Legal First MI Last

DOB: ______________________ **Sex**: _____ Female ______ Male

Mailing Address:

____

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City State Zip

Preferred Contact Information:

Home #: (____)______________

Cell # : (____)______________

Email : ______________________

How did you hear about our office? ☐ Internet ☐ Facebook ☐ Friend/Family: _____________

Emergency Contact: ______________________________________

Name 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

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DOB Social Security

Secondary Insurance: ______________________

Policy #: ______________________

Group #: ______________________

Policy Holder: ______________________

Legal First MI Last

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DOB Social Security

Medical/HIPAA Information Release

Freedom Prosthetic & Orthotics, LLC. has my consent to use or disclose my protected health information to complete my treatment and to obtain payment from my insurance company(s). 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 understand that I/the patient may ask to see or obtain a copy of the current notice at any time and I was provided a copy either during this visit or previous visit.

☐ 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: ________________