PATIENT INFORMATION FORM

Social Security#: - -

(Mr. Mrs. Ms.) Patient Name: Date of Birth:

Address: City: State: Zip:

Phone# :( ) Cell# :( ) Married? Y/N

Parent/Guardian Name:

Emergency Contact Name: Phone# :( ) Relationship To Patient:

Living In A Nursing Facility: Y/N If Yes, Facility Name: Phone#:( )

Employer Name: Work#: ( )

Email Address: Would you like us to text you appointment reminders? Y/N

Medical History:

Referring Physician: Primary Physician:

Are you Diabetic? Y/N Name of Diabetic Physician: Phone Number# :( )

Insurance Information:

Primary Insurance Name: Address:

Policy#: Group#: Policy Holder Name:

Policy Holder Date of Birth: / / Policy Holder Social#:

Secondary Insurance Name: Address:

Policy#: Group#: Policy Holder Name:

Policy Holder Date of Birth: / / Policy Holder Social#:

Worker's Compensation:

Ins Company: Phone Number: ( ) Claim Number:

Date of Injury: Claims Adjuster: Employer:

AUTHORIZATION TO ASSIGN BENEFITS TO PROVIDER & RELEASE OF MEDICAL INFORMATION:

I request that payment of authorized Medicare, Medicaid, Private Insurance and Other Benefits be made on my behalf to the above company for products and services that they have provided for me. I further authorize a copy of this agreement to be used in place of the original and authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid services and its Agents or Others, any information needed to determine these benefits or compliance with current health standards. I acknowledge having received a copy of Capstone Orthopedic Inc.'s 1) Notice of Privacy Policies, 2) Medicare Supplier Standards and 3) Financial Policy.

Signature of Patient/ Responsible Party **Today's Date**

Printed Name of Responsible Party **Relationship to Patient**

FINANCIAL POLICY

If you are covered by insurance

Douglass Certified Prosthetics & Orthotics, Inc. will bill your insurance on your behalf. Verification of benefits and authorization is not a guarantee of payment from your insurance and is typically based on medical necessity. If you have doubts that your insurance will not pay, please contact your insurance to discuss with them your current benefits. You are responsiblefor any amounts not paid by your insurance.

Patients with non-contracted insurance, non-covered services and or private pay

If the services we provide total less than $500.00, payment is due at the time of delivery unless other payment arrangements are made. Services of over $500.00, a deposit of half the amount is due at the time of evaluation and agreement to proceed with the service; the balance is due upon delivery of the item, unless other payment arrangements are made.

We accept cash, checks, Visa and Mastercard. Any return checks will result in a $30 bank fee for NSF.

If you are unable to make the final payment upon delivery of item, please inform us so that other payment options can be arranged.

I have read, received and understand Douglass Certified Prosthetics & Orthotics, Inc. financial policy

_____ _____

Signature of Patient / Responsible Party Date

CAPSTONE orthopedic

Assignment of Benefits/Authorization to Release Information/Authorization to Treat

I, the undersigned patient / responsible party consent to the medical procedures, treatments and examinations to be provided for the rendering of an orthosis, prosthesis and / or related services from this date forward.

I authorize any holder of medical or other information about me (including but not limited to chart notes, photographs and/or models) which are obtained in connection with my treatment be released to Centers for Medicare & Medicaid Services (CMS) and its agents, Champus/TRICARE and it agents or any other private or government insurance agency and/or its agents as needed to determine these benefits or benefits related services. I permit a copy of this authorization to be used in place of the original.

I request that payment of Medicare, Medicaid or private insurance benefits be made to Capstone Orthopedic, Inc. for any covered services provided by Capstone Orthopedic, Inc. In addition, I agree to pay Capstone Orthopedic, Inc., the deductible and/or coinsurance due.

I am responsible and agree to pay for the following expenses: any service that my insurance deems non-covered or not medically necessary, all coinsurance/copayment amounts, all deductibles, any amount above the benefit limitations on my policy and any amount not covered because I was not insured at the time of service.

Furthermore, I verify that all the information provided by me is true, accurate and complete.

I acknowledge having received 1) a copy of Capstone Orthopedic Inc.'s Privacy Policy, 2) Capstone Orthopedic Inc.'s Financial Policy, 3) Medicare Supplier Standards, and 4) Warranty and Patient Responsibilities Information.

_____ _____

Patient or Responsible Party Signature Date

_____

Patient's Printed Name

If Responsible Party, please complete the following:

_____

Printed Name

_____

Address

Relationship to Patient: _____

Reason patient is unable to sign: _____

For Notice of Privacy Practices only, please describe the Responsible Party's authority to act on the behalf of the patient: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of our patients' protected health information (PHI) and to provide patients with notice of our legal duties and privacy practices with respect to your PHI. We are required to abide by the terms of this notice while it is in effect. This Notice takes effect Sept. 23, 2013 and will remain in effect until we replace it. We reserve the right to change the terms of this Notice of Privacy Practices as necessary, provided such changes are permitted by applicable law.

EXAMPLES OF USE AND DISCLOUSURE FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

Treatment: We may use or disclose your health information to other medical professionals involved in your care. We may also release your PHI to another facility or professional who is not affiliated with our organization but who is or will be providing services or parts related to your treatment.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, and certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your PHI for treatment, payment or healthcare operations, you may give us written authorization to use your PHI or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your PHI for any reason except those described in the Notice.

To Your Family and Friends: We must disclose your PHI to you, as described in the Patient Rights section of this Notice. With your approval, we may from time to time disclose your PHI to designated family members, friends or others who are involved in your care or in payment of your care to the extent necessary to help with your healthcare or with payment for your healthcare. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited PHI with such individuals without your approval. We may also disclose limited PHI to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

Business Associates: Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as auditing, accreditation, legal services, etc. at times it may be necessary for us to provide certain aspects of your PHI to one or more of these outside organizations who assist us with our healthcare operations or treatment. In all cases, we require these business associates to appropriately safeguard the privacy of your information.

USES AND DISCLOSURES THAT REQUIRE AN AUTHORIZATION

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Sale of PHI: We will not sell your protected health information without your written authorization.

REQUIRED USES AND DISCLOSEURES

Required by Law: We may release your PHI when we are required to do so by law or by subpoena/discovery request.

Abuse or Neglect: We may release your PHI to appropriate authorities if, in limited instances, we suspect a serious threat to the health or safety of you or others.

National Security: We may release your PHI if you are a member of the military as required by armed forces services; we may also release PHI to authorized federal officials if necessary for national security or intelligence activities.

Workers' Compensation: We may release PHI to workers' compensation agencies if necessary for your workers' compensation benefit determination.

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of Douglass Certified Prosthetics & Orthotics, Inc the information belongs to you. You have the right:

- To copy and/ or inspect your PHI that we retain on your behalf. All requests for access must be made in writing and signed by you or your representative.
- To request that PHI that we maintain about you be amended or corrected. We may deny your request under certain circumstances. All requests must be in writing, signed by you or your representative and must state the reasons for the amendment/correction request.
- To receive a list of instances in which we or our business associates disclosed our PHI for up to 6 years prior to the date of request. Requests must be in writing and signed by you or your representative. If you request this accounting more than once in a 12-month period, you will be charged a fee for responding to these additional requests.
- To request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522. We will honor your request for restrictions to the extent possible. We are not required to agree to your restriction request, unless required by law or you request a restriction to a health plan if you have paid for the services out of pocket and in full. We will attempt to accommodate reasonable requests when appropriate and we retain the right to terminate and agreed-to-restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination, you also have the right to terminate, in writing or orally, any agreed-to-restriction.
- To be notified of a breach of unsecured PHI in the event you are affected.
- To obtain additional copies of the Notice of Privacy Practices upon request.

By signing I am stating that I have received this Notice of Privacy Practices, read and understood the above statements.

Name:_____ Date:_____

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you believe your privacy rights have been violated, or disagree with a decision we made about access to your PHI or in response to a request you made to amend or restrict the use or disclosure of your PHI or to have us communicate with you by alternative means or at alternative locations you can file in writing with the Douglass Certified Prosthetics & Orthotics, Inc. Privacy Officer or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.