Height__________________

Weight__________________

Patient Information (please print)

Patient Name:____Prevail ID #______________

S.S. # :_____________________________Date of Birth:_____________________Gender: Male Female

Address: ____

City State Zip

Phone:____________________________________E-mail address:___________________________________

Does the patient currently live in a nursing facility? Yes No If yes, please name______________________________

MEDICARE PATIENTS: Have you received another orthotic in the past 5 years? Yes No

Insurance Information:

Policy Holders Name:____

Address:____

City State Zip

Phone:____________________________________ Relationship to Patient:_____________________________

Date of Birth:_______________________________ Employer:_____________________________________

In Case of Emergency Contact:

Name_________________________Relationship:____________________Phone:________________________

Medical Information

Referring Doctor:__________________________________Primary Care Doctor:_________________________

Is the patient Diabetic? Yes No Diabetic Doctor:____

Physical Therapy Facility, if any:____

If you're receiving items for your foot/leg please provide your shoe size:__________________________________

Employment

Patient's Employer:______________________________________Phone:_______________________________

May we contact you at work? Yes No

******Please Read******

My signature authorizes Prevail to treat myself, or my dependent, as well as affirming my understanding that Prevail is acting solely as an agent for filing insurance benefits assigned to it. Prevail assumes no responsibility for guaranteeing payment of covered charges. Benefits quoted to me from Prevail are strictly that, a quote. Charges may be incurred per the insurance carrier. I understand that I am fully responsible for all deductibles, coinsurance and disallowable at the time services are rendered. I recognize and affirm my obligation to pay Prevail the total of all charges incurred, and this obligation is in no way dependent upon reimbursement under any medical insurance plan. I authorize payments be made directly to Prevail through my insurance plan(s), which shall not affect my obligation to pay the remaining balance. I authorize the release of any medical information necessary to process this claim through Prevail Prosthetics & Orthotics, Inc. I understand this authorization does not expire and is valid beginning on the date of signature below. I have the right to revoke this authorization at any time, in writing. I acknowledge that I have received, or was provided an opportunity to read, the Supplier Standards, HIPAA Privacy Information and the Patient Bill of Rights and Responsibilities.

____

Signature of Patient, Parent/Guardian, or Authorized Representative Date

Prevail Prosthetics & Orthotics Payment Policy & Fee Notification

I understand that it is my responsibility to know who my insurance carrier is in and out of network with. I acknowledge I am responsible for payment if my insurance carrier deems the procedure is out of network. Prevail is acting as an agent for filing insurance benefits assigned to it however, Prevail assumes no responsibility for guaranteeing payment from my insurance carrier. I also acknowledge that, if they are not contracted to do so, Prevail is under no obligation to file an insurance claim or write appeals on my behalf, and does so as a courtesy. I understand that I am fully responsible for all deductibles, co-insurance and all other fees, including non-covered charges. I recognize and affirm my obligation to pay Prevail the total for all charges incurred, and this obligation is in no way dependent upon reimbursement from any insurance plan. Any arrangement whereby payments are made directly to Prevail through any insurance plan shall not affect my obligation to pay the remaining balance.

FEES AND PAYMENTS

Our goal is to provide the best orthotic and prosthetic care and services. We make every effort to keep our fees reasonable and to avoid unfairly passing on to our patients the cost of unnecessary collection procedures. Therefore, all co-pays, co-insurance and deductibles are due at the time services are rendered. There will be a late fee of $10 per month on any amount past due. There will also be a $20.00 fee for all bounced/returned checks. In the event that a collection agency must intervene due to non-payment, you will be responsible for any court costs, late fees and reasonable attorney fees.

INSURANCE/VA

Please remember that your insurance policy is a contract between you (as a policy holder) and the insurance carrier. It does not release you of financial responsibility for services rendered and is not a substitute for payment. We do accept insurance assignment.

Private Insurance Assignment of Benefits: I hereby authorize my insurance company to make payment directly to Prevail for all services they provide me.

VA patients: By signing this you are authorizing us to file a claim with the VA and authorizing them to make payment directly to Prevail. If we have a purchase order on file, you have already been approved for your service.

STATE MEDICAL ASSISTANCE (MEDICAID)

We are a licensed provider for Medicaid in the State of Indiana. We will verify your coverage and obtain all necessary authorizations. Some Medicaid patients have a spend-down and may be required to pay some expenses out-of-pocket. If you do not know if you have a spend-down, please ask our office staff for assistance in obtaining this information.

MEDICARE/ ASSIGNMENT OF BENEFITS

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request the payment of authorized benefits be made on my behalf directly to Prevail Prosthetics & Orthotics, Inc.. I assign the benefits payable for covered insurance services to Prevail Prosthetics & Orthotics, Inc. and authorize such organization to submit a claim to Medicare and other applicable insurance carriers for payment.

WORKER'S COMPENSATION

If your equipment has been prescribed due to a work related injury and is to be turned in under workman's compensation, we need to have a name and phone number of someone we can contact before we issue your prosthetic or orthotic device. If we can not verify coverage or if the coverage is in question, you may be asked to pay for the device in full on the day the service is rendered.

AUTOMOBILE INSURANCE

If the device we are providing is a result of an injury from an auto accident, we will need phone numbers, claim numbers, and names of all insurance companies involved. Generally, the auto insurance companies pay the insured for services, or the claim turns into a legal issue. We ask that you pay in full for the device that we provide you at the date of service. If the carrier does send payment directly to Prevail, we will gladly refund any money due to you.

I, as the patient or responsible party, have read and understand the above and authorize the release of information for the purpose of reimbursement of insurance benefits. I realize I am responsible for any charges incurred in this facility. I authorize the release of any medical information necessary to process claims.

____

Signature of patient/responsible party   Date

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices (HIPPA) and the Patient Bill of Rights and Responsibilities and/or have been provided the opportunity to review them.

Patient's Name: ____ Date of birth:____________________

____

Signature of Patient or Parent/Guardian   Date

Prevail has my permission to release medical information and/or payment information to the following:

Name____________________________Relationship:______________________Phone:___________________________

Name____________________________Relationship:______________________Phone:___________________________

Name____________________________Relationship:______________________Phone:___________________________

Name____________________________Relationship:______________________Phone:___________________________

Name____________________________Relationship:______________________Phone:___________________________

Name____________________________Relationship:______________________Phone:___________________________

Name____________________________Relationship:______________________Phone:___________________________

Name____________________________Relationship:______________________Phone:___________________________

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION TO PREVAIL PROSTHETICS & ORTHOTICS, INC.

Patient's Name: ____ Date of Birth:____________________________

Previous Name, when applicable: ____

Social Security #:____

I authorized the following records be provided to Prevail Prosthetics & Orthotics, Inc. to prove the medical necessity of my prescribed device(s) and as needed for insurance requirements and guidelines. This authorization applies to:

☐ Healthcare information relating to the following treatment, condition or dates:____________________________

____

☐ All healthcare information

☐ Other:____

____

Notice: Sexually Transmitted Disease (STD, as defined by law, RCW 70.24, includes herpes, herpes simplex, human papilloma virus, warts, genital warts, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, HIV (Human Immunodeficiency Virus) AIDS (Aquired Immunodeficiency Symdrome) and gonorrhea.)
I understand that medical records may contain information regarding STD results, HIV/AIDS testing, whether negative or positive. I understand that Prevail cannot release this information to anyone without my written permission. I further understand that records may also contain information regarding drug and/or alcohol abuse and treatment, as well as mental health treatment. My signature authorizes the release of said information. I have the authority to revoke this authorization at any time and must do so in writing to Prevail Prosthetics & Orthotics, Inc.

There is a potential that the information Prevail is given can or will be re-disclosed to other parties who request them, such as your insurance carrier(s) to prove medical necessity, in compliance with HIPAA regulations.

____ ____________________
Signature of Patient or Parent/Guardian if minor Date

____ ____________________
Printed Name Relationship to patient

Authorization expires 1 calendar year after signature date