PATIENT REGISTRATION FORM

Legal Name of Patient: _____ Gender: (M) (F) Marital Status: ___M ___D ___S

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____ SSN: _____

Date of Birth: _____ Parent or Legal Guardian if Patient is a Minor: _____

Employer's Name: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Who may we speak with other than yourself regarding your medical care: _____ Phone: _____

Emergency Contact: _____ Phone: _____

May we leave a message on your voice mail at home _____ cell _____work _____?

May we mail medical information to your home? Yes _____ No _____

Injured Body Part: Left _____ Right _____ Diagnosis: _____ Date of Injury: _____

WORK CONPENSATION PATIENTS ONLY

Name of physician who referred you to this office: _____ Is this a work ____ or auto ____ accident?

Name of Claim Carrier: _____ Phone: _____ Name of Adjuster: _____

Claim #: _____ Address: _____ City: _____ State: ____ Zip: _____

HEALTH INSURANCE INFORMTION

Primary Insurance Co: _____ Phone: _____ Policy ID#: _____

Group #: _____ Address: _____ City: _____ State: _____ Zip: _____

Secondary Insurance Co: _____ Phone: _____ Policy ID#: _____

Group #: _____ Address: _____ City: _____ State: ____ Zip: _____

Policy Holder Name: _____ Relationship to Patient: _____

Person Responsible for Payment: _____ Insured _____ Patient _____ Other

ASSIGNEMNT OF BENEFITS/FINANCIAL RESPONSIBILITY/ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby assign to Audubon Orthotic and Prosthetic Services (AOPS) any and all rights to receive insurance benefits otherwise payable to me for products or services provided by AOPS. I understand that my signature requests that payment by my insurance carrier be made directly to AOPS. I authorize AOPS to appeal denied insurance authorization and/or benefits on my behalf.

For Medicare patients: I hereby understand that Audubon has made available Medicare Supplier Standards.

In the event, that my insurance carrier does not accept an assignment of benefits, I understand that all correspondence and payments to AOPS may be sent directly to me, and that when such payments are received, I will hold them in trust to AOPS for payment of my bill. I agree to assume financial responsibility for any claim or portion of claim thereof, due to AOPS for supplies and services not covered by my insurance policy, as of the date of service. If my insurance company denies coverage for all or any product billed, or if my insurance coverage changes and payment is denied, I will assume financial responsibility for payment. In Medicare assigned cases, AOPS agrees to accept the charge determination of the Medicare carrier as the full charge. **I am responsible for the deductible, co-insurance, and non-covered services and denied payment.**

I understand that AOPS has a legal obligation to seek payment from me for coinsurance amounts owed and that this agreement supercedes and will prevail over any other agreement to the contrary. I acknowledge that I have been provided a Notice of Privacy Practices.

I understand, acknowledge and agree to the terms set forth above. All above information is correct and complete.

Date: _____ Signature: _____