OrthoPro
Prosthetics+Orthopedic Bracing

OrthoPro
Patient Information Form

PATIENT INFORMATION

Last Name:	First Name:	Middle Initial:	Preferred Name:

Date of Birth:	Gender: (check one) Male ☐ Female ☐	SSN:	E-mail Address:
Mailing Address	City	ST	Zip Code
Primary Language:			
Marital Status	Home Phone:	Ok to Leave Message: Yes ○ No ○	Cell Phone:
Ok to Leave Message: Yes ○ No ○			
How Did You Hear About Us? ☐ Other:_____ ☐ Doctor/Hospital ☐ Patient ☐ Friend/Family ☐ Internet			How may we contact you? Phone: Yes ○ No ○ Email: Yes ○ No ○
Referring Doctor:	Primary Care Doctor:		

RESPONSIBLE PARTY INFORMATION (PARENT/GUARDIAN)

Guarantor Name:	Address:	Phone Number:	Ok to Leave Message: Yes ○ No○
E-Mail Address:	Date of Birth:	Relationship to Patient:	

EMERGENCY CONTACT / WHO WE CAN COMMUNICATE WITH REGARDING APPOINTMENTS AND MEDICAL INFO.

Name (First, Last):	Relationship to patient:	Phone:	OK to Leave a Message:
			Yes ○ No○
			Yes ○ No○

PHYSICIAL THERAPY INFORMATION

Yes ○ No ○

Are you currently or have you recently worked with a physical and/or occupational therapist?
If yes, please answer the following: **Physical Therapist** ○ **Occupational Therapist** ○
Name of Therapist: _____ **How often?** _____

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INSURANCE INFORMATION ***PLEASE PROVIDE YOUR INSURANCE CARD**

Please Check Box if SELF Pay ☐

Worker's Comp Case: YO NO If yes, please fill out below:

Employer at Time of Injury:	Date of Injury:
Claim Number:	Carrier Name:
Adjuster Name:	Adjuster Phone Number:

1. Primary Insurance Company		ID #:		
Subscriber Name:	Relationship to Patient:	Phone #:	DOB:	SSN:
2. Secondary Insurance Company		ID #:		
Subscriber Name:	Relationship to Patient:	Phone #:	DOB:	SSN:

ADDITIONAL INFORMATION

Yes O No O Have you received a like or similar device within the last 5 years from either OrthoPro or any other provider?

Yes O No O Are you currently residing in a nursing home, assisted living or group home?
If yes, Name of Facility: _____
Phone Number: _____

Yes O No O Have you received a motorized wheelchair within the last 5 years?

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OrthoPro
Privacy Practices Acknowledgment, Consents, and Assignment of Benefits

Acknowledgment of Receipt of Notice of Privacy Practices and Company Policies

By signing below, I certify that OrthoPro has made available to me a Notice of Privacy Practices. 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 OrthoPro healthcare operations. The Notice of Privacy Practices also describes my rights and OrthoPro's duties with respect to my protected health information. OrthoPro reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised 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.

Consent for Contact

I, the undersigned, consent to be contacted by OrthoPro by phone call, e-mail, US Postal Service or other means to follow-up on my care.

Use of Images

By signing below, I understand that OrthoPro may use my likeness in a photograph or video as part of its marketing efforts including but not limited to publication in external communication and social media posts. I waive the right to inspect or approve the finished product wherein my likeness occurs. Additionally, I waive any right to royalties or other compensation related to the use of those images.

Consent to Provide Services and/or Products

I understand that by signing this agreement, I indicate my wish to purchase orthotic and/or prosthetic products or services, or both, from OrthoPro. I understand that I am under the supervision and care of my attending physician. I understand that my physician has prescribed the orthosis/prosthesis noted as part of my treatment. I also understand that due to the nature of the products supplied by OrthoPro that they cannot be returned.

Assignment of Benefits

I, the undersigned, hereby authorize OrthoPro to request on my/our behalf and to collect directly all public and private insurance benefits due for products and/or services supplied to me by OrthoPro. In the event payments for insurance benefits are made directly to any of the undersigned, the payee will endorse to OrthoPro all checks for such payments.

Consent to Coordinate Care and Release of Medical Records

By signing below, I authorize all medical personnel to provide information to OrthoPro concerning my medical history, as it may relate to my treatment. This includes collecting medical information from any physician, surgeon, medical facility and/or physical therapist seen by me. OrthoPro will comply with all HIPAA rules and regulations.

Insurance Coverage

By signing below, I agree to inform OrthoPro of any changes in my insurance coverage. If my insurance coverage changes or is terminated, I understand that I am responsible for all charges of services and devices delivered to me or in fabrication.

Patient Name Printed	Patient Date of Birth
Patient/Guardian Signature	Date
Guardian Printed Name	Relationship to Patient

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OrthoPro
Medical History Form

Patient Name: **Today's Date:**

MEDICAL HISTORY

Diagnosis: _____

Relevant Surgeries: _____

MEDICAL CONDITIONS (CHECK ALL THAT APPLY):

☐ Heart Problems	☐ Hepatitis A, B or C	☐ Vision Problems	☐ Pacemaker/Defibrillator
☐ Hypertension	☐ Cerebral Palsy	☐ Parkinson Disease	☐ Seizure Disorder
☐ Vascular Disease	☐ HIV Positive	☐ Alzheimer Disease	☐ Scoliosis/ Kyphosis
☐ Stroke	☐ Rheumatoid Arthritis	☐ Spina Bifida	☐ Currently Pregnant
☐ Diabetes	☐ Obesity	☐ Clubfoot	☐ MRSA/ VRE
☐ Kidney Disease	☐ Osteoarthritis	☐ Muscular Dystrophy: _____	
☐ Osteoporosis	☐ Pulmonary Disease (TB)	☐ Other: _____	

Medications: _____

IDENTIFY ALL THAT IS TRUE TO HELP US IDENTIFY A PROPER TREATMENT PLAN:

STRENGTH/ MOBILIBTY:
- ☐ Falls are never an issue
- ☐ Near-falls are an issue for me
- ☐ I currently use a prosthetic/ orthotic device
- ☐ I have used a prosthetic/ orthotic device in the past
- ☐ I currently use an assistive device (cane, Walker, crutches, etc.)
- ☐ Other: _____

DIFFICULT WALKING CONDITIONS FOR ME INCLUDE:
- ☐ Uneven terrain
- ☐ Ascending/ descending Stairs
- ☐ Ascending or descending hill/ ramp
- ☐ Snow/ ice
- ☐ Other: _____

WORK DETAILS:
- ☐ I am currently not working
- ☐ My job is _____
- ☐ My job requires use of stairs
- ☐ My job requires prolonged standing
- ☐ My job requires walking long distance or duration
- ☐ My job includes difficult walking conditions

MY DAILY ACTIVIES INCLUDE:
- ☐ Shopping
- ☐ Preparing meals
- ☐ Cleaning my home
- ☐ Performing yardwork
- ☐ Walking the dog

LIVING SITUATION:
- ☐ I live alone
- ☐ I live with _____
- ☐ I care for children at home
- ☐ I must use stairs at home
- ☐ There are difficult walking conditions around my home

MY HOBBIES/OTHER ACTIVITIES INCLUDE:
- ☐ Long walks
- ☐ Hiking
- ☐ Running
- ☐ Gardening
- ☐ Other: _____

OTHER PERTINENT INFORMATION:

Signature | Print Name | Relationship to Patient

Originated: February 17, 2020

SAVE RESET PRINT

Payment Policy

Thank you for choosing us for your prosthetic and orthotic needs. We are committed to providing you with quality and affordable health care. Please read our payment policy, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Custom Devices**. **If you are being provided with a custom device it cannot be returned**. We will make adjustments needed to ensure the devices fits properly. If your device is made and you do not show up for delivery your insurance will still be billed for the device since it cannot be returned.
2. **Prosthetic Supplies (liners ,sleeves, socks), non-stock, and special order items:** May not be returned or refunded. All other items will be reviewed on a case by case basis.
3. **Insurance.**. It is your responsibility to know your healthcare coverage. We participate with most insurance plans, including Medicare. We do not participate with United Healthcare, some Cigna & Aetna plans and other insurance companies. If you are not insured by a plan we are contracting with, payment is due in full when fabrication begins. If you are insured by a plan that we are contracting with, your portion of the payment for services provided will be due before fabrication.
4. **Benefits.** Knowing your insurance benefits is your responsibility. You are responsible for your entire bill should your insurance company not pay any of the anticipated charges for any reason. Please contact your insurance company with any questions you may have regarding your policy. If you need help in doing so please let us know, we would be happy to assist you.
5. **Deductible and Co-insurance.** We require that all co-payments are made on the day of your visit. We are unable to set-up payment arrangements. We accept cash, check, Visa/MasterCard and Care Credit.
6. **Non-covered services.** Please be aware that some -and perhaps all- of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. This is why it is very important to check your benefits before your visit.
7. **Proof of Insurance.** All patients must provide complete insurance information before seeing a practitioner. We must obtain a copy of your current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim.
8. **Claims Submission.** We will submit your claims and assist you in any way reasonable to help get your claims paid. Your insurance company may need you to supply certain information directly to them. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not a party to that contract. If your insurance company has not paid on services within 45 days, we ask that you contact them with regards to their processing.
9. **Coverage Changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.
10. **Nonpayment.** If your account is over 60 days past due, we will add a finance charge of $10 per month. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members will no longer be able to obtain service through our office.
11. **Missed appointments.** We will not charge for missed appointments. After multiple missed appointments you will no longer be scheduled into our office and you will be referred back to your physician.
12. **Minor patients.** It is our policy that an adult will accompany minor patients. The parent who accompanies the minor to our office is responsible for the charges incurred and billings to any other party.
13. **Returned Checks.** For all returned checks there will be a $25.00 charge.

Our office is committed to providing the best treatment to our patients. Thank you for understanding our financial policy. If you have any questions regarding this payment policy, please refer them to the administrative team.

I have read and agree with the Payment & Policy agreement. I also certify the information provided by me is true, accurate and complete to the best of my knowledge.

_____ _____

Patient/Parent/Guarantor Signature Date

_____ _____

Patient/Parent/Guarantor Printed Name Relationship to Patient

If the patient is 18 or older the patient must sign

OrthoPro

Prosthetics+Orthopedic Bracing

1437 Parkview Drive, Suite 200, Twin Falls, ID 208-733-0505
1600 Overland Ave, Suite C, Burley, ID 208-878-0500

PHOTO CONSENT FORM

Patient Name: _____ Date: _____

Photos & videos of patients will be taken as part of your medical record to document goals & outcome measures and to help with medical necessity justification for insurance payment, if needed.

I consent for medical photographs and/or videos to be taken of me by OrthoPro of Twin Falls or a representative. I understand that the information may be used in my medical record or for purposes of medical teaching. By consenting to these medical photographs and/or videos I understand that I will not receive payment from any party. Although these photographs and/or videos will be used without identifying information such as my name, I understand that it is possible that someone may recognize me. Refusal to consent to photographs will in no way affect the medical care I will receive. If I wish to withdraw my consent in the future, I may do so with a written request.

I authorize the use of images: (Please initial indicating YES or NO below)

_____YES _____NO For demonstration purpose including an office photo album

_____YES _____NO On our website or social media for prospective patients

_____YES _____NO In print advertisements.

By signing this form below I confirm that this consent form has been explained to me in terms which I understand.

_____ _____

Patient Name Signature/Date Patient Printed Name

_____ _____

Witness Name Signature/Date Witness Printed Name

OrthoPro

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1437 Parkview Dr, Suite 200, Twin Falls, ID 83301 Phone: 208-733-0505, Fax: 208-735-2117
1600 Overland Ave, Suite C, Burley, ID 83318, Phone: 208-878-0500, Fax: 208-735-2117

Authorization to Disclose Patient Health Information:

_____ _____
(print full name of the patient) (patient's date of birth)

_____ _____
(address, city, state, zip) (phone number)

I hereby AUTHORIZE OrthoPro of Twin Falls, Inc. to RELEASE to:

_____ located at _____
(physician, clinic, spouse, child, other) (address, city, state, zip)

INFORMATION TO BE RELEASED IS:

_____ All clinical records _____ Other (specify)_____

In____ Paper or ___ Electronic Form (specify format)_____

For the following dates: from _____ to _____

I authorize release of my medical records as listed above and understand that my authorization will remain in effect unless I cancel by written notice.

_____ _____
(patient/legal guardian signature) (date)