CHOICE LIMB & BRACE
555A SOUTH COLUMBUS AVENUE
MOUNT VERNON, NEW YORK 10550
PH: 914-479-0743 FAX: 914-479-1568

MRN #: _____ **SSN:** _____-_____-_____

PATIENT INFORMATION/ INFORMACION DEL PACIENTE

*(Name Last/ Apedillo) _____, *(First/Primero) _____, (M) _____ **MALE/ FEMALE**

*Emergency Contact NAME/ Contacto de Emergencia: _____ PHONE #: _____

*Address/ Dirreccion: _____ CELL #: _____

_____ APT#: _____ HOME#: _____

CITY: _____ STATE: _____ ZIP CODE: _____ WORK #: _____

EMAIL: _____

*Date of Birth/ Fecha de Nacimiento: _____ /_____/ _____HEIGHT/ALTURA: _____WEIGHT/PESO: _____ AGE/ANOS: _____

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*Prescribing Doctor: _____ Phone #: _____

Address: _____ Fax #: _____

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*ACCIDENT RELATED: Y / N DATE OF ACCIDENT: _____

***PRIMARY INSURANCE:** _____ **ID#:** _____

Subscriber/ Parent Name: _____ *SUBSCRIBER/PARENT DOB: _____ / _____ / _____

***SECONDARY INSURANCE:** _____ **ID#:** _____

Subscriber/ Parent name: _____ *SUBSCRIBER/PARENT DOB: _____ / _____ / _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE:

I certify that I have received an overview of CHOICE LIMB & BRACE INC. Notice of Privacy practices with access to a full copy. The notice of privacy practices describes the uses and disclosures of my protected health information that might occur in my treatment, payment of bills or in the performance of CHOICE LIMB & BRACE INC. duties with respect to my protected health information. The notice of Privacy practice is posted at: 555A South Columbus Avenue Mount Vernon New York 10550. Choice Limb & Brace INC. 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 and requesting a revised copy be sent to me in the mail or by asking for one at my next appointment.

I have read, understand, and agree to all of the above.

_____ _____

SIGNATURE/ FIRMA (PATIENT, PARENT, GUARDIAN) **TODAY'S DATE/ FECHA**

_____

Please print name

The above information is true. Any information that may not be truthful may slow the handling of my claim and delay the receipt of my device. I authorize CHOICE LIMB & BRACE Inc. to bill my insurance company and I understand that I am financially responsible for any products and services provided to me. If my insurance provider is covering the cost, I know that am still responsible for any payments they do not make, including the balance remaining after insurance payments. I agree that any balances not paid within 30 days of receipt of device will be subject to a 1.5% monthly interest fee.

OFFICE USE ONLY: _____

_____

_____

Choice Limb and Brace, Inc.
Orthotics and Prosthetics

PATIENT CONSENT AND ACKNOWLEDGEMENT FORM

Patient Name: _____ DOB: _____

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I have been given a copy of Choice Limb and Brace INC. Notice of Privacy Practices and understand these rights. I also understand that it is my responsibility to notify the Privacy officer in writing of any restrictions to my patient file. Forms are available through the Privacy Officer upon request.

CONFIDENTIAL/ LIABILITY RELEASE

I hereby consent and grant permission for Practitioners' employed by Choice Limb and Brace INC. to discuss my medical treatment for orthotics and/or prosthetics, with my referring physician, primary care physician, physical therapist, occupational therapist, hospital and/or rehabilitation staff, relating to my care and treatment. I also understand that it is my responsibility to notify the Privacy Officer upon request.

CONSENT TO TREAT

I hereby authorize Choice Limb and Brace INC. to perform evaluations and/or treatment services on me/my child.

FINANCIAL POLICY

I understand that I am responsible for payment of charges and that payment is due at the time of services, or I hereby assign insurance benefits to be paid directly to Choice Limb and Brace INC. I understand that I am responsible for charges not covered by my insurance policy.

RELEASE OF INFORMATION & AUTHORIZATION

I hereby consent and permit a copy of this authorization and assignments to be used in place of this original signed document. I understand that this original will be placed in my patient file to be kept at the medical provider's office.

I hereby authorize any practitioner examining and/or treating my child/ me. To release to any third party (such as an insurance company or governmental agency) any medical information and records concerning the diagnosis and treatment when requested for use in determining payment of claims.

I hereby consent and authorize Choice Limb and Brace INC. to file claims for treatment, electronically or manually to my insurance carrier(s) for service rendered to me.

ASSIGNMENT OF BENFITS

I hereby consent and authorize payment to be paid directly to provider Choice Limb and Brace INC. for services rendered for any orthotic and/or prosthetic services and treatment. Any services for which assignment is not accepted are acknowledged as being my full and complete financial responsibility.

I have read, understand and agree to all of the above.

_____ _____

Parent/ Legal Guardian Signature **Date**