NEW PATIENT INFORMATION

800-524-4447

First Name: ____________________ M.I ________ Last Name: ________________________

DOB: __________ SSN: _______-______-_________ Marital Status: _________________

Mailing Address: ________________________________ City: __________________________

ST: ________ Zip: ________ Patient Phone #: ____________________________

Male: ______ Female: _____ Height: ________ Weight: ________________

Shoe Size: _______ Primary Care Physician: ____

Referring Physician: ________________________ Allergies: _____________________________

Emergency/Secondary Contact Person: _______________ Number: ________________

Are You Diabetic? Y____ N___ Estimate when diagnosed: _____________________

Are You Filing this Claim Through Worker's Comp.? Y____ N_____
Date of Injury: ____________
Worker's Comp. Adjustor Name: _________________ Number: _______________________

COMMUNICATION AUTHORIZATION

I AUTHORIZE BRISTOL ORTHOTICS & PROSTHETICS TO LEAVE MESSAGE ON MY PRIMARY PHONE NUMBER.
YES _______ NO_______

I CAN ALSO BE CONTACTED AT THE FOLLOWING EMAIL ADDRESS: __________________________
I GIVE PERMISSION TO BRISTOL ORTHOTICS & PROSTHETICS TO COLLECT MY HEALTHCARE INFORMATION FROM MY PHYSICIANS OR ANY OTHER MEDICAL CARE PROVIDER IN ORDER TO RECEIVE PAYMENT FOR THEIR SERVICES &/OR DEVICE. I HEREBY AUTHORIZE BRISTOL ORTHOTICS & PROTHETICS, INC. TO USE MY EMAIL ADDRESS FOR THE PURPOSE OF ROUTINE COMMUNICATION, INCLUDING, BUT NOT LIMITED TO, IMPROVING THE QUALITY OF ITS SERVICES. THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE.

____ DATE: ______________________
PATIENT/CAREGIVER SIGNATURE

CONSENT FOR USE OR DISCLOSURE OF HEALTHCARE INFORMATION & FINANCIAL RESPONSIBILITY AGREEMENT

OUR PRIVACY PLEDGE

WE ARE VERY CONCERNED WITH PROTECTING YOUR PRIVACY. WHILE THE LAW REQUIRES US TO GIVE YOU THIS DISCLOSURE, PLEASE UNDERSTAND THAT WE HAVE, AND ALWAYS WILL RESPECT THE PRIVACY OF YOUR INFORMATION. THERE ARE CIRCUMSTANCES IN WHICH WE MAY HAVE TO USE OR DISCLOSE YOUR INFORMATION. SUCH AS: WE MAY HAVE TO DISCLOSE YOU INFORMATION AND BILLING RECORDS TO ANOTHER PARTY IF THEY ARE POTENTIALLY RESPONSIBLE FOR THE PAYMENT OF YOUR SERVICES.

YOU HAVE THE RIGHT TO REQUEST THAT WE DO NOT DISCLOSE YOUR HEALTH INFORMATION TO SPECIFIC INDIVIDUALS, COMPANIES, &/OR ORGANIZATIONS. IF YOU WOULD LIKE TO PLACE RESTRICTIONS ON THE USE OR DISCLOSURE OF YOUR HEALTH INFORMATION, PLEASE LET US KNOW IN THE WRITING BELOW THIS PARAGRAPH.

IF CUSTOM MADE ORTHOTICS ARE NOT COVERED BY YOUR INSURANCE, HALF OF THE TOTAL COST IS DUE AT THE TIME YOUR ARE CASTED/MEASURED, WITH THE REST OF THE BALANCE DUE WHEN YOU ARE FITTED.

MEDICARE SUPPLIER STATEMENT

THE PRODUCTS &/OR SERVICES PROVIDED TO YOU BY SUPPLIER BRISTOL ORTHOTICS & PROSTHETICS, INC. ARE SUBJECT TO THE SUPPLIER STANDARDS CONTAINED ON THE FEDERAL REGULATIONS SHOWN AT 42 CODE OF FEDERAL REGULATIONS SECTION 424.57@. THESE STANDARDS CONCERN BUSINESS PROFESSIONAL AND OPERATIONAL MATTERS (E.G., HONORING WARRANTIES & HOURS OF OPERATION). THE FULL TEXT OF THESE STANDARDS CAN BE OBTAINED FROM THE U.S GOVERNMENT PRINTING OFFICE WEBSITE. UPON REQUEST, WE WILL FURNISH YOU A WRITTEN COPY OF THE STANDARDS.

I GIVE PERMISSION TO BRISTOL ORTHOTICS & PROSTHETICS, INC. TO COLLECT MY HEALTHCARE INFORMATION FROM MY PHYSICIANS IN ORDER TO RECEIVE PAYMENT FOR THEIR SERVICES &/OR DEVICE.

PLEASE SIGN BELOW FOR EITHER THE TOP SECTION OR FOR BOTH SECTIONS IF BOTH ARE APPLICABLE.

____

PATIENT'S NAME PRINTED

____

PATIENT'S SIGNATURE/RESPONSIBLE PARTY/REPRESENTATIVE'S SIGNATURE

______________________________ DATE: ______________________

RELATIONSHIP TO PATIENT

DOCUMENTATION FOR WRITTEN INSTRUCTION INFORMATION ON BENEFICIARY USE/MAINTENANCE OF SUPPLIES

PROSTHETIC, ORTHOTIC DEVICES & THERAPEUTIC SHOES: PROSTHETIC DEVICES ARE TYPICALLY DEVICES THAT SUBSTITUTE PART OF A BODY PART. ORTHOTIC DEVICES ARE DEVICES THAT ARE USED TO SUPPORT WEAK BODY PART/PARTS OR RESTRICT MOVEMENT IN AN INJRED OR DEFORMED PART/PARTS OF THE BODY.

ORTHOTIC AND PROSTHETIC DEVICES INCLUDE CUSTOM FABRICATION (MADE SPECFICALLY FOR THE PATIENT), MOLDED TO PATIENT (EITHER A MODEL THROUGH PLASTER OR DIGITAL IMAGING TECHNOLOGY), POSTIVE MODEL OF THE PATIENT (NEGATIVE IMPRESSION OF THE PATIENT TAKEN AND USED TO CONSTRUCT THE PART), CUSTOM FITTED (MADE WITHOUT A SPECIFIC PATIENT IN MIND BUT CUSTOMIZED FOR SPECIFIC PATIENT ON AN AS NEEDED BASIS), PROSTHETIC DEVICE (MADE TO REPLACE A CERTAIN BODY PART, INCLUDING SOMATIC PROSTHESES AND EXTERNAL BREAST PROSTHESES), ORTHOTIC DEVICES (MADE TO SUPPORT A PATIENT'S INJURED OR WEAK BODY PART), AND THERAPEUTIC SHOES AND INSERTS.

ALTHOUGH NO SET UP IS REQUIRED FOR PROSTHETIC AND ORTHOTIC DEVICES, THE SUPPLIER IS STILL OBLIGATED TO PROVIDE THE BENEFICIARY OR THEIR CAREGIVER WITH APPROPRIATE TRAINING &/OR INSTRUCTIONS. THIS CONSISTS OF TELLING THE BENEFICIARY: HOW TO USE, CLEAN & ADJUST THE DEVICE, HOW TO INSPECT THE SKIN FOR ANY ADVERSE REACTIONS TO THE DEVICES SUCH AS NECESSARY FOLLOW-UP APPOINTMENTS; AND HOW TO CREATE AN APPROPRIATE SCHEDULE FOR WEARING THE DEVICE. FINALLY, THE SUPPLIER MUST PROVIDE TOOLS NECESSARY FOR THE MAINTENANCE OF THE DEVICE, SUCH AS CLEANING TOOLS.

- FOLLOW UP PROCEDURES FOR PROSTHETIC AND ORTHOTIC DEVICES: IN ADDITION TO THE GENERAL FOLLOW UP PROCEDURES, SUPPLIERS MUST: (A) HAVE ACCESS TO A FACILITY THAT CAN EFFECTIVELY MODIFY ORTHOTICS OR PROSTHESES & PROVIDE FOLLOW-UP CARE. (B) SOLICIT FEED BACK ON THE TREATMENT FROM THE BENEFICIARY OR CAREGIVER & MODIFY THE ORTHOTICS OR PROSTHESES AS NECESSARY; AND (C) REVIEW PRODUCT MAINTENANCE PROCEDURES WITH THE CAREGIVER &/OR BENEFICIARY. IN ADDITION, THE SUPPLIER IS OBLIGATED TO ASSIST THE BENEFICIARY UNTIL THE DEVICE HAS REACHED WHAT IS DETERMINED TO BE AN OPTIMAL LEVEL OF FUNCTION AND FIT IN ACCORDANCE WITH THE PATIENT'S TREATMENT PLAN.

I HAVE READ AND ACKNOWLEDGE THE ABOVE:

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PATIENT &/OR CAREGIVER SIGNATURE

DATE: ________________________________