MAHAFFEY ORTHOTICS & PROSTHETICS

Section 1 – Patient Information

First:_______________________**Middle**_______________ **Last**:____________________________________
SSN:_________________________ **Date of Birth**:_____________________
Marital Status: Single / Married / Other **Sex**: Male / Female
Home Address:____________________________ **City**:__________________ **State**:______ **Zip**:___________
Mailing Address: __________________________ **City**__________________ **State**: _____ **Zip**____________
Home Tel #:_________________ **Work Tel #**:__________________ **Mobile #**:____________________
Patient's Employer: ____
Employer's Address: ____________________ **City**: ___________ **State**: ________ **Zip**: _______________
Spouse's Name: _______________________ **Work Tel #**:______________ **SSN**: __________________

Section 2 – Parent / Guardian / Responsible Party

Name (Last, First, MI):____
SSN: ____________________ **Date of Birth**: _________________________
Relationship to Patient: Spouse / Parent / Guardian / Other (Explain) ___________________________
Employer: ____ **Tel #**: _______________
Employer's Address: ____________________ **City**: __________________ **State**: ________ **Zip**: ________

Section 3 – Emergency Contact

Name (Last, First, MI):____
Work Tel #:___________________ Home Tel #:____________________ Relationship: ____________

Section 4 – Medical Information

Height: ____________ **Weight**: _____________
Diagnosis: ____**Date of injury**: _________________
If Amputation, Amputation Date: _________ Level of Amputation: ________ Amputation Side: R L BIL
How/Where did the injury occur: ____
Primary Care Physician: __________________________________ **Tel #**:_________________________
Referring Physician/Referral Source: ________________________ **Tel #**:_________________________
Are You Diabetic? Y / N (if yes answer next question)
Physician Managing Diabetes: ______________________________ **Tel #**:____________________

Section 5 – Insurance Information

Is this a Worker's Comp Claim? Y / N (if yes, please complete **WORKER'S COMP** form)

(IF WE MADE A COPY OF YOUR CARD YOU DO NOT HAVE TO FILL THIS SECTION OUT.)

Primary Insurance: ______________________
Policyholder: ____________________________
Policyholder DOB: _______________________
Policyholder SSN: ________________________
Group #: ___________ ID #: _______________
Case Mgr: ___________ Tel #: _____________
Patient's Relationship to Policyholder: ________

Secondary Insurance: _________________________
Policyholder: ___________________________________
Policyholder DOB: ______________________________
Policyholder SSN: ______________________________
Group #: _______________ ID #: __________________
Case Mgr: _______________ Tel #: _______________
Patient's Relationship to Policyholder: ______________

MAHAFFEY ORTHOTICS & PROSTHETICS

PATIENT ACKNOWLEDGEMENT FORM

As part of the admission process, you will be receiving information on several policies and procedures that we have implemented to ensure you treatment while in our care is of the highest quality. This acknowledgement indicated your receipt of such information at the time of you initial registration or patient contact.
* PLEASE INITIAL THE FOLLOWING ITEMS AFTER READING THE PROVIDED INFORMATION

__________ **Patient Bill of Rights –** This details you rights as a patient.

__________ **Warranty Policy** – Describes Mahaffey Orthotics & Prosthetics policies with respect to warranty period and repairs/ adjustments.

__________ **Payment and Policy Agreement** – This explains Mahaffey Orthotics & Prosthetics policies w3ith respect to billing and your insurance and collecting applicable co-pays and deductibles.

__________ **Urgent Care** – Informs you of our urgent care procedures.

__________ **Patient Complaint Process** – This notifies you of our complaint and resolution process.

__________ **Medicare Supplier Standards** – Outlines standards that are to be maintained by Mahaffey Orthotics & Prosthetics as a Medicare provider.

__________ **Consent to Treat** – I hereby authorize Mahaffey Orthotics & Prosthetics to provide requested orthotic and/or prosthetic device.

__________ **Assignment of Benefits** – I hereby authorize Mahaffey Orthotics & Prosthetics to release necessary medical information to my insurance carrier(s) to process my medical claim. I also authorize my insurance carrier to pay benefits directly to Mahaffey Orthotics & Prosthetics.

YES / NO Have you received a like or similar device within the last five (5) years from either Mahaffey Orthotics & Prosthetics or any other provider?

YES / NO Are you currently residing in a nursing home?

YES / NO Do you have surgery scheduled to treat the same condition for which this device will be utilized? If so, when? ___________________

I request that payment of authorized Medicare Benefits be made to Mahaffey Orthotics & Prosthetics on my behalf for any services furnished to me by Mahaffey Orthotics & Prosthetics. I authorize anyone who holds medical or other information about me to release that information to the Center for Medicare and Medicaid Services and its agent in order to determine these benefits or benefits for related services.

I, the undersigned, have received, read and understand these policies and agreements and hereby consent to the above as indicated by my initials. I also attest that the above questions have been answered truthfully to the best of my knowledge.

SIGNATURE: ____ **DATE: ______________**

ACKNOWLEDGEMENT of RECEIPT of NOTICE of PRIVACY PRACTICES

I certify that I have received a copy of Mahaffey Orthotics & Prosthetics' 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 Mahaffey Orthotics & Prosthetics health care operations. The Notice of Privacy Practices also describes my right and Mahaffey Orthotics & Prosthetics duties with respect to my protected health care information. The Notice of Privacy Practices is posted in the lobby.

Mahaffey Orthotics & Prosthetics reserves the right to change the privacy practices that are described in the Notice of Privacy Practices by calling the office and requesting a revised copy by sent in the mail or asking for one at the time of my nest appointment.

____

Signature of Patient or Personal Representative

____

Name of Patient or Personal Representative

____

Date

____

Description of Personal Representative