Patient Intake Form

Patient ID: _____

Patient Information:

Patient's Last Name: _____First: _____Middle:_____

Legal Gender: M__ F__ Date of Birth: _____/_____/_____ Height: _____ Weight: _____

Mailing Address: _____ Apt #_____

City: _____ State: _____Zip Code: _____-_____

Home Phone #: _____ Mobile Phone #:_____Alternate Phone #:_____

Use this as primary phone ☐ Use this as primary phone ☐ Use this as primary phone ☐

☐**Consent to Call**: *OP Specialty Bracing is permitted to call and or leave messages on the Mobile Phone # above*

☐**Consent to Text**: *OP Specialty Bracing is permitted to send text message appointment reminders to the Mobile Phone # above*

Email Address: _____

(Your Email Address will be kept confidential and will only be used to contact you for a patient satisfaction survey or staff correspondence)

Referring Physician: _____ _____Phone # (if known) _____

Primary Care Physician: _____ _____Phone # (if known) _____

Is the patient involved in any of the following programs? (Select all that apply)

Early Intervention Agency Name: _____ Therapist: _____ Phone #: _____

Physical Therapy Agency Name: _____ Therapist: _____ Phone #: _____

Occupational Therapy Agency Name: _____ Therapist: _____ Phone #: _____

Specialty School/Program Name: _____ Contact: _____ Phone #: _____

_____

Guarantor Information: *(Person who is Financially Responsible for this Patient)*

Patient's Relationship to Guarantor: _____

Name *(first/last)*: _____ Date of Birth: _____/_____/_____

Address: *(If different)* _____

Insurance Information:

Is This Visit Related to a Worker's Comp or Motor Vehicle Injury? **Yes ☐ No ☐ If Yes, please request & complete the Injury detail form.**

Primary Insurance Company: _____ **Policy Id #**: _____

Policy Holder's Name: _____ Date of Birth: _____/_____/_____

Relationship to Patient: _____

Secondary Insurance Company: _____ **Policy Id #**: _____

Policy Holder's Name: _____ Date of Birth: _____/_____/_____

Relationship to Patient: _____

Please continue to next page →

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PLEASE READ EACH OF THESE STATEMENTS THOROUGHLY AND SIGN BELOW.
SIGNING BELOW IS ACKNOWLEDGEMENT THAT YOU HAVE
READ, UNDERSTAND AND AGREE TO EACH STATEMENT.

1. **Benefits, Medical Information Release Authorization and Acknowledgement of Financial Responsibility**
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to OP Specialty Bracing. I understand that I am financially responsible for any balance. I authorize the release of any information necessary to provide services or process claims.
2. **Research:** Clinical measures, that are part of our standard clinical process and help direct patient care such as weight, height, age, Cobb angle, curve(s) apex, thermal sensor hours, head circumference, width, depth, left to right diagonal length; range of motion, and the visual gait scale are regularly collected to determine the effectiveness of treatments. All data is confidential and is identified with a code. This allows the identity of the patient to be linked to the research data, but decoding can only be done by the principal investigator or a delegated person. There is no known or anticipated physical inconvenience to participate since the data collected is typical for the specific appointment type. You do have the right to refuse to have your/your child's data used as this is voluntary. This will in no way negatively impact your care as this data is part of your individual medical record and used to direct care. This information may be shared with researchers/physicians that refer patients to us for purposes of their research and quality control.
3. **Acknowledgement of Receipt of Notice of Privacy Practices:** I certify that I have received a summary copy of the OP Specialty Bracing Notice of Privacy Practices. A full copy is available at this office or online at www.opsb.com
4. **Acknowledgement of Medicare DMEPOS Supplier Standards (for Medicare patients only):** The products and/or services supplied to you by OP Specialty Bracing are subject to the supplier standards contained in the Federal regulations. The full text of these standards can be obtained at http://www.ecfr.gov. Upon request, we will provide you with a written copy of the standards.
5. **Acknowledgement of OP Specialty Bracing Payment and Refund Policies:** For custom items, full payment of coinsurance and deductible is required before the device is ordered or fabricated. For prefabricated items that are in stock, full payment of coinsurance and deductible is due at fitting. Items provided are non-returnable and non-refundable once you leave the office.
We will make sure that you are satisfied and comfortable with the device before you leave. Any adjustments will be made free of charge.
6. **Acknowledgement of OP Specialty Bracing Financial Policies**
   - ⇒ Unpaid balances for prior services are due before you can receive new services.
   - ⇒ It is the patient/guardian's responsibility to be sure that all information for primary and secondary insurance is up to date and correct for every appointment. Failure to submit this information will result in being financially responsible for all services rendered.
   - ⇒ We will call your insurance company to verify benefits, coinsurance and deductible and provide you with an estimate for services. Benefits quoted by your insurance company are not a guarantee of payment. Payment for coinsurance and deductible will be requested when you approve the estimate. While we make every attempt to provide you with an accurate estimate, it's only an estimate until your insurance company processes the claim.
   - ⇒ Your insurance company may require us to obtain an authorization to provide services. This may delay the delivery of your device since we cannot order or fit without the insurance authorization.
   - ⇒ If we request authorization for Out of Network (OON) benefits with your insurance provider, we do not accept the payer's rate for those services. You will be responsible for the reasonable and customary charges for the device.
   - ⇒ We bill your insurance company when you receive your device. Please keep this in mind if you are changing plans or your plan's renewal date is coming up; your estimate for coinsurance and deductible may change.
   - ⇒ If you are a Workers' Compensation patient, it's your responsibility to provide us with the information to process your claim. You can be held responsible for charges in the event that your claim is controverted.
   - ⇒ Returned checks will be subject to a $35 fee. Unpaid balances may be subject to collection placement and collection fees.

_____

Signature of Patient or Personal Representative **Date**

_____

Printed Name of Patient or Personal Representative

_____

Description of Relationship to Patient (Self, Parent, Spouse, Sibling, Guardian, Friend, Caregiver, etc.)

_____Notice given to patient; no parent/guardian available to sign