Pongratz Orthotics & Prosthetics, Inc.

Patient Name: ____________________ Birthdate: __________

Street Address: ____________________ Sex: Male Female

City, State, Zip: ____________________ Height: __________

Email Address: ____________________ Weight: __________

Cell Phone: ____________________ Employment Status: __________

Home Phone: ____________________ Marrital Status: __________

Work Phone: ____________________ Language: __________

Social Security #: ____________________ Are you Diabetic? Yes No

Are you a resident in a Skilled Nursing Facility, Assisted Living, Specialty Hospital, or Rehab? Yes No

Have you ever received a silmilar device? Yes No If yes, How Long Ago? __________

Referring Physician: ____________________ Phone: __________

Primary Care Physician: ____________________ Phone: __________

Diabetic Doctor: ____________________ Phone: __________

Physical Therapist: ____________________ Phone: __________

EMERGENCY CONTACTS: Spouse, Parent, Guardian, etc. (If patient is a minor this section must be completed fully)

Name: ____________________

Home Phone: ____________________

Cell Phone: ____________________

Relation to Patient: ____________________

INSURANCE INFORMATION

Primary Insurance: ____________________ Secondary: __________

Policy/ID #: ____________________ Policy/ID#: __________

Group #: ____________________ Group #: __________

Policy Holder: ____________________ Policy Holder: __________

Policy Holder DOB: ____________________ Policy Holder DOB: __________

Relationship: ____________________ Relationship: __________

Workmans Comp Case: Yes No Date of Injury: __________

Insurance Carrier: ____________________ Claim#: __________

Adjuster: ____________________ Employer at DOI: __________

Adjuster's Phone: ____________________ Employer's Phone: __________

I hereby authorize the release of information regarding my/the patient's condition/treatment, as necessary to process this and/or related claims. I also certify that all information contained herin is accurate and correct.

Signature: Patient or Responsible Party (circle one) Date:

PONGRATZ ORTHOTICS & PROSTHETICS, INC.

Patient Consent for Purposes of Treatment, Payment, and Healthcare Operations Pongratz Orthotics & Prosthetics, Inc. (“FACILITY”)& Acknowledgment of Receipt of Notice of Privacy Practices

Patient Consent:

By signing this form, I consent to the use or disclosure of my protected health information by **FACILITY** for the purpose of providing treatment to me, obtaining payment for my health care bills or to conduct **FACILITY's** health care operations. I understand that I have the right to revoke the consent, in writing, at any time, except to the extent that the **FACILITY** has taken action in reliance on my prior consent.

My “protected health information” means any of my written and oral health information, including my demographic data that can be used to identify me, that has been created or received by **FACILITY**, and that relates to my past, present or future physical or mental health or condition.

I understand I have a right to review **FACILITY's** Notice of Privacy Practices prior to signing this document. 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 our health care operations. The Notice of Privacy Practices also describes my rights and **FACILITY's** duties with respect to my protected health information. The Notice of Privacy Practices is posted in the front lobby and on **FACILITY's** website, if available.

As noted in **FACILITY's** Notice, **FACILITY** reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I understand that I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, asking for one at the time of my next appointment, or accessing **FACILITY's** website.

I understand I have the right to request restrictions as to how my protected health information is used or disclosed to carry out treatment, payment or our healthcare operations. **FACILITY** is not required to agree to the restriction that I may request, but if it does it is bound by its agreement.

I understand that diagnosis or treatment of me by **FACILITY** may be conditioned upon my consent as evidenced by my signature on this document.

Patient Acknowledgment:

I certify that I have received a copy of **FACILITY's** 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 **FACILITY's** health care operations. The Notice of Privacy Practices also describes my rights and **FACILITY's** duties with respect to my protected health information. The Notice of Privacy Practices is posted in the front lobby and on **FACILITY's** website, if available.

FACILITY 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, asking for one at the time of my next appointment, or accessing **FACILITY's** website.

AUTHORIZATION:
I hereby authorize the release of information regarding my/the patient's condition/treatment, as necessary to process this and/or related claims. **I understand that I am responsible for all fees not covered by insurance, Medicare, Medical Assistance or other Governmental Agencies, or Worker’s Compensation.**

MEDICARE DMEPOS SUPPLIER STANDARDS

The products and/or services provided to you by Pongratz Orthotics & Prosthetics are subject to the supplier standards contained in the Federal regulations shown at 42 Code of Federal Regulations Section 424.57(c). These standards concern business professional and operational matters (e.g. honoring warranties and hours of operation). The full text of these standards can be obtained at http://ecfr.gpoaccess.gov. Upon request we will furnish you a written copy of the standards.

________________________________   ____________________
Printed Patient Name   DOB

________________________________   ____________________
Signature of Patient or Guardian   Date

CUSTOM ITEMS POLCY:

Due to the nature of custom made devices we have a no return policy. I understand that once I give approval to have my custom made device started there are no cancellations and payment will be due prior to starting my order. If for any reason I do not return for delivery of my device or cancel the order after the custom made item(s) have been started Pongratz reserves the right to bill my insurance/patient upon completion of my custom made device.

OFFICE POLICY ON PAYMENT:

It is our policy to require payment of all office charges at the time they are given unless prior arrangements have been specifically made. All accounts over 90 days will be charged an interest rate of 1 ½ percent per month (18% per annum) or a $2.00 minimum. In the event any balance due hereunder is not paid as agreed, the undersigned jointly and severally agree to pay all costs charged by the collection company, whose costs will not exceed 30% of said unpaid balance, including a reasonable attorney's fee.

INSURANCE POLICY:

Insurance: Your current insurance card is required at the time of each check- in or must be on file in order for us to bill your charges to your insurance company. If we do not have a copy of your current insurance card, you will be required to pay for services rendered. When the card is provided we will, at that time, file the claim to your insurance and reimburse you after the claim has been paid. **You are responsible for all deductibles and charges not covered by insurance.** Please understand that we cannot, as a third party, become involved in prolonged insurance negotiations; this is your responsibility.

I authorize the release of any medical information necessary to process any claim. I permit a copy of the authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

AUTHORIZATION TO PAY:

I hereby authorize payment directly to the business office of this physician/clinic for surgical and or medical benefits, if any, otherwise payable to me for services rendered.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS:

I authorize the staff to release any medical information including photographs of my condition, diagnostic information, x-rays, test results, reports and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for any of the following purposes: diagnostic, insurance, legal, and at times when the staff deems it necessary in order to ensure that best medical care on my behalf. I further understand that any person(s) who receive(s) these medical records will not release any of the medical information obtained by this authorization to any other person or organization without further authorization signed by me for release of the information. I also authorize Pongratz to request medical records from any other provider for the purposes of obtaining medical history related to my condition.

I have read the above and accept financial responsibility in full for this account.

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Printed Patient Name Date Of Birth

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Signature of Patient or Guardian Date