Restore Orthotics and Prosthetics
Patient Information Form

PATIENT INFORMATION

Last Name:	First Name:	Middle Initial:	Preferred Name:

Date of Birth:	Gender:	SSN:	E-mail Address:

Mailing Address	City	ST	Zip Code	Primary Language:

Marital Status:	Home Phone:	Ok to Leave Message: Yes ○ No ○	Cell Phone:	Ok to Leave Message: Yes ○ No ○

How Did You Hear About Us?
☐ Doctor/Hospital ☐ Patient ☐ Friend/ Family ☐ Internet Search

How may we contact you?
Text: Yes ○ No ○ Email: Yes ○ No ○

GUARANTOR INFORMATION:

Guarantor Name:	Address:	Phone Number:	Ok to Leave Message: Yes ○ No ○

E-Mail Address:	Date of Birth:	Relationship to Patient:

EMERGENCY CONTACT:

Name:	Relationship to Patient:	Phone Number:	Ok to Leave Message: Yes ○ No ○

PLEASE LIST OTHER INDIVIDUALS WHO WE CAN COMMUNICATE WITH REGARDING APPOINTMENTS AND MEDICAL INFO.

Name (First, Last):	Relationship to patient:	Phone:	OK to Leave a Message:
			Yes ○ No ○
			Yes ○ No ○

INSURANCE INFORMATION ***PLEASE PROVIDE YOUR INSURANCE CARD**

Please Check Box If SELF Pay ☐ Worker's Comp Case: **Y** ○ **N** ○

1. Company Name:	☐ Primary ☐ Secondary	ID #:

Subscriber Name:	Relationship to Patient:	Phone #:	DOB:	SSN:

2. Company Name:	☐ Primary ☐ Secondary	ID #:

Subscriber Name:	Relationship to Patient:	Phone #:	DOB:	SSN:

RESTORE
ORTHOTICS AND PROSTHETICS

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PHYSICIAL THERAPY INFORMATION

Yes ○ No ○ Are you currently or have you recently worked with a physical and/or occupational therapist?

If yes, please answer the following: **Physical Therapist** ○ **Occupational Therapist** ○

Name of Therapist: _____**How often?** _____

ADDITIONAL INFORMATION

Yes ○ No ○ Have you received a like or similar device within the last 5 years from either Restore Orthotics and Prosthetics or any other provider?

Yes ○ No ○ Are you currently residing in a nursing home, assisted living or group home?

If yes, Name of Facility: _____

Phone Number: _____

Yes ○ No ○ Have you received a motorized wheelchair within the last 5 years?

Payment and Policy Agreement

Your insurance policy is a contract between you and your insurance company to help you meet medical expenses. Because benefits can vary greatly, it is not possible for Restore Orthotics and Prosthetics to provide services on the basis that your insurance company will pay all charges.

Restore Orthotics and Prosthetics can in no way guarantee coverage. Benefits are determined by your insurance plan at the time your claim is processed. All benefit calculations are only an estimate, based on information obtained from your insurance company. The actual Total Patient's Responsibility may be different than what was previously estimated by Restore Orthotics and Prosthetics.

To prevent any misunderstanding about medical insurance, we wish to point out that: (1) Payment for all medical services furnished are the responsibility of the patient; (2) Deductibles, co-payments, and/or other patient responsibility amounts are due at the time services are rendered; (3) For deductibles, co-insurance and non-covered custom-made devices **fifty percent (50 %)** of the balance is due at the casting appointment, with **the balance due at the time of delivery**; (4) Restore Orthotics and Prosthetics will bill your insurance company as a courtesy to you; however, Restore Orthotics and Prosthetics is not responsible for non-payment from the insurance company; (5) If, due to unforeseen circumstances, additional procedures and/or treatments are necessary beyond what has been previously approved, patients must make arrangements for payment; (6) Patients are expected to keep their accounts current while waiting for their insurance company to remit payment.

In consideration of Restore Orthotics and Prosthetics efforts to supply patients with products and/or services to the patient, the patient or guarantor agree that each of them is responsible for payment. Payments may be made by check, money order, Visa or MasterCard. A $20.00 fee will be assessed for any check returned for any reason.

NO REFUNDS will be given for the following items: CUSTOM MADE ITEMS, PROSTHETIC SUPPLIES (LINERS, SLEEVES, SOCKS), NON-STOCK, and SPECIAL ORDER ITEMS. All other items will be reviewed on a case by case basis.

Patient Complaint Process

We are committed to ensuring you are completely satisfied with the services and care you receive at Restore Orthotics and Prosthetics. However, if for any reason you wish to file a complaint, any staff member can assist you in this confidential matter. You will be asked to complete a "Patient Complaint Form" to assist us in understanding your complaint or concern fully. Once the form is received, a company representative will investigate the complaint thoroughly and take the necessary actions to satisfy your complaint.

I have read and agree with the Payment and Policy agreement. I also certify the information provided by me is true, accurate and complete to the best of my knowledge.

_____ _____

Patient/ Parent/ Guarantor Signature Date

_____ _____

Patient/ Parent/ Guarantor Printed Name Relationship to Patient

***If the patient is 18 or older the patient must sign**