



Patient Information

PATIENT INFORMATION

Last Name:	First Name:	MI	Preferred Name:
Date of Birth:	Gender:	Marital Status:	Social Security Number:
Mailing Address: Street / City, State / Zip Code		Email Address:	
Home Address: Street / City, State / Zip Code		Address on file with Medicare: ☒ Home ☐ Mailing	
Primary Language:	Home Phone:	OK to leave message? ☐ Yes ☒ No	Cell Phone: OK to leave message? ☐ Yes ☐ No
How did you hear about us?		Contact Preference:	
Referring Doctor:	Primary Care Doctor:		

RESPONSIBLE PARTY INFORMATION

Guarantor First & Last Name:	Date of Birth:	Relationship to Patient:	Phone Number:	OK to leave message? ☐ Yes ☐ No
Email Address:	Mailing Address: Street / City, State / Zip Code			

EMERGENCY CONTACT / POC FOR APPOINTMENTS AND MEDICAL INFO

Emergency First & Last Name:	Relationship to Patient:	Phone Number:	OK to leave message? ☐ Yes ☐ No
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INSURANCE INFORMATION - PLEASE PROVIDE YOUR INSURANCE CARD -

Worker's Comp Case: ☐ Yes ☐ No		Check for Self Pay: ☐ Yes ☐ No	
Worker's Comp Company/Adjuster:		Contact Number:	
Primary Insurance Company:		ID#:	
Subscriber Name:	Relationship to Patient:	Phone Number:	DOB: SSN:
Secondary Insurance Company:		ID#:	
Subscriber Name:	Relationship to Patient:	Phone Number:	DOB: SSN:

PHYSICAL THERAPY INFORMATION

Are you currently or have you recently worked with a physical and/or occupational therapist? YES ☐ NO ☐

If yes, please answer the following: Physical Therapist ☐ Occupational Therapist ☐ How Often?

Name:

ADDITIONAL INFORMATION

Have you received a like or similar device within the last 5 years from either Restore O&P or any where else? YES ☐ NO ☐

Are you currently residing in a nursing home, assisted living, or group home? YES ☐ NO ☐

If yes, please answer the following: Facility Name: Phone Number:

Have you received a motorized wheelchair within the last 5 years? YES ☐ NO ☐

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 O&P to provide services on the basis that your insurance company will pay all charges. Restore O&P 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 O&P.

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 O&P will bill your insurance company as a courtesy to you; however, Restore O&P 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 O&P 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 \$40.00 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 O&P. 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 Name, Printed

Relationship to Patient

If patient is 18 years or older, patient must sign.

Privacy Practices Acknowledgment, Consents, and Assignment of Benefits

Acknowledgment of Receipt of Notice of Privacy Practices and Company Policies

By signing below, I certify that Restore O&P has made available to me a 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 Restore O&P healthcare operations. The Notice of Privacy Practices also describes my rights and Restore O&P duties with respect to my protected health information. Restore O&P 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, or asking for one at the time of my next appointment.

Consent for Contact

I, the undersigned, consent to be contacted by Restore O&P by phone call, e-mail, US Postal Service or other means to follow-up on my care.

Use of Images

By signing below, I understand that Restore O&P may use my likeness in a photograph or video as part of its marketing efforts including but not limited to publication in external communication and social media posts. I waive the right to inspect or approve the finished product wherein my likeness occurs. Additionally, I waive any right to royalties or other compensation related to the use of those images.

Consent to Provide Services and/or Products

I understand that by signing this agreement, I indicate my wish to purchase orthotic and/or prosthetic products or services, or both, from Restore O&P. I understand that I am under the supervision and care of my attending physician. I understand that my physician has prescribed the orthosis/prosthesis noted as part of my treatment. I also understand that due to the nature of the products supplied by Restore O&P that they cannot be returned.

Assignment of Benefits

I, the undersigned, hereby authorize Restore O&P to request on my/our behalf and to collect directly all public and private insurance benefits due for products and/or services supplied to me by Restore O&P. In the event payments for insurance benefits are made directly to any of the undersigned, the payee will endorse to Restore O&P all checks for such payments.

Consent to Coordinate Care and Release of Medical Records

By signing below, I authorize all medical personnel to provide information to Restore O&P concerning my medical history, as it may relate to my treatment. This includes collecting medical information from any physician, surgeon, medical facility and/or physical therapist seen by me. Restore O&P will comply with all HIPAA rules and regulations.

Insurance Coverage

By signing below, I agree to inform Restore O&P of any changes in my insurance coverage. If my insurance coverage changes or is terminated, I understand that I am responsible for all charges of services and devices delivered to me or in fabrication.

Medicare DMEPOS Supplier Standards Acknowledgment

Our practice complies with the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Supplier Standards as outlined in 42 CFR § 424.57(c). By signing below, you acknowledge that you have been offered a copy of the Supplier Standards.

Patient Name, Printed

Patient Date of Birth

Patient / Guardian Signature

Date

Guardian Name, Printed

Relationship to Patient

Patient Name:		Date:
Diagnosis:	Relevant Surgeries:	

MEDICAL CONDITIONS (CHECK ALL THAT APPLY)

- | | | | |
|---|--|---|--|
| ☐ Heart Problems | ☐ Hepatitis A, B, or C | ☐ Vision Problems | ☐ Pace Maker / Defibrillator |
| ☐ Hypertension | ☐ Cerebral Palsy | ☐ Parkinson Disease | ☐ Seizure Disorder |
| ☐ Vascular Disease | ☐ HIV Positive | ☐ Alzheimer Disease | ☐ Scoliosis / Kyphosis |
| ☐ Stroke | ☐ Rheumatoid Arthritis | ☐ Spina Bifida | ☐ Currently Pregnant |
| ☐ Diabetes | ☐ Obesity | ☐ Clubfoot | ☐ MRSA / VRE |
| ☐ Kidney Disease | ☐ Osteoarthritis | ☐ Muscular Dystrophy: _____ | |
| ☐ Osteoporosis | ☐ Pulmonary Disease (TB) | ☐ Other: _____ | |
| ☒ Medications: _____ | | | |

IDENTIFY ALL THAT ARE TRUE TO HELP US IDENTIFY A PROPER TREATMENT PLAN

Strength / Mobility

- ☐ Falls are never an issue
- ☐ Near-falls are an issue for me
- ☐ I currently use a prosthetic/orthotic device
- ☐ I have used a prosthetic/orthotic device in the past
- ☐ I currently use an assistive device (cane, walker, etc.)
- ☐ Other: _____

Work Details

- ☐ Currently not working
- ☐ Current job is _____
- ☐ My job requires use of stairs
- ☐ My job requires prolonged standing
- ☐ My job requires walking long distance or duration
- ☐ My job includes difficult walking conditions

Living Situation

- ☐ Live alone
- ☐ Living with _____
- ☐ Care for children at home
- ☐ Must use stairs at home
- ☐ Encounter difficult walking conditions at my home

Difficult Walking Conditions for Me

- ☐ Uneven terrain
- ☐ Ascending / descending stairs
- ☐ Ascending / descending hills or ramps
- ☐ Snow / Ice
- ☐ Other: _____

Daily Responsibilities

- ☐ Shopping
- ☐ Preparing meals
- ☐ Cleaning home
- ☐ Yard work
- ☐ Walking the dog
- ☐ Other: _____

Hobbies and Activities

- ☐ Long Walks
- ☐ Hiking
- ☐ Running
- ☐ Gardening
- ☐ Other: _____

Additional Pertinent Information:

Patient / Guardian Signature

Date

Guardian Name, Printed

Relationship to Patient