CONSENT and PREFERENCE for Healthcare Messaging

These forms MUST be fully completed

Name: ____

My Email Address: _____________________________________

My Phone Number: ____________________________________

Email and Text Messaging Consent

I hereby state my preference to have Restorative Prosthetics & Orthotics (RPO) practitioners and staff communicate with me by email or standard SMS (text) messaging regarding prescriptions, appointments, reminders, and billing. I understand that email and SMS messaging are not confidential and there is a risk that e-mail and SMS messaging might be intercepted and read by a third party. I also understand that I may withdraw this consent at any time by resubmitting this form to RPO.

I consent to email/text messaging communication with Restorative P & O

☐ Yes ☐ No

I prefer to receive my appointment reminders in the following method

☐ Text message/Email ☐ Phone call/Voicemail

I authorize RPO to discuss my healthcare as indicated with the following individual:

Name: ____

Relationship: ____

Phone: ____

Yes☐ No☐ Appointment Reminders Yes☐ No☐ Billing Information

______________________________ ______________________

Patient or Guardian Signature Date

For Office Use Only: Account #: _______________

PATIENT INFORMATION (*Please Print All Information)* Date: ____________________________

Last Name: _________________________________ First Name: _______________________________ MI: ____________

Street Address: ____ Apt #: _______City: _____________________________

State: ________ Zip Code: ____________**Primary Phone** #: Cell/Home/Work/Other: (______) _____________________

Phone # 2: Cell/Home/Work/Other:(______) _______________________ Birth Date: _____-_____-_______Age: ______

Male: ☐ Female: ☐ Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other ☐

Social Security #: _________ - _______ - __________

RESPONSIBLE PARTY *(if patient is a minor, please complete this section)* Self/Same as above: ☐

Last Name: _________________________________ First Name: _______________________________ MI: ____________

Street Address: ____ Apt #: ______________

City: ____________________________State: ________ Zip Code: ____________ Birth Date: ______________ Age: ____

Phone # 1: Cell/Home/Work:(______) ______________________ Phone # 2: (_____) _____________________________

Male: ☐ Female: ☐ Social Security #: _________ - _______ - __________

E-Mail Address: __________________________________ Relationship to Patient: _______________________________

ACKNOWLEDGEMENT OF RECEIPT

I certify that I have received a copy of the Restorative Prosthetics & Orthotics (RPO) Notice of Privacy Practices and Patient Bill of Rights, Medicare Supplier Standards, Warranty Information, Mission Statement and Patient Responsibilities contained in the patient brochure.

*X*____ _____________________

Patient/Guardian Signature **Date**

RETURN POLICY

Federal Law PROHIBITS re-use of medical supplies and equipment. Therefore, RPO cannot accept any prescribed items for return or refund except in cases of manufacturer defects.

ASSIGNMENT OF BENEFITS

I hereby assign all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and any other health/medical plan, to issue payment directly to Restorative Prosthetics & Orthotics, a division of Restorative Health Services Group for services rendered to myself and/or my dependents.

PAYMENT AGREEMENT

I agree that in the event my insurance or other third-party payor refuses to pay the rental or purchase price of the equipment or service, that I will be responsible for those payments. If for any reason my account should become delinquent, I agree to pay for all billing charges, interest charges, collection fees, and reasonable legal fees. Collection calls may be made to any phone number (including cell phone numbers) that you have provided to us. I give permission for RPO to contact me by mail, phone, or voice mail message, to schedule, re-schedule, or remind me of appointments or to inform me of any insurance carrier information pertinent to my service or products being rendered.

RELEASE OF INFORMATION

I authorize any of my medical providers to release to RPO any information including protected health information (PHI) necessary for the purpose of preauthorizing or billing services or goods received at RPO. I further authorize RPO to release medical records to my referring medical provider(s). I understand that this PHI will not be used for any other purposes other than outlined above and will be subject to all HIPPA rules and regulations concerning personal health information. I also understand this release is valid as long as I am under the care of the practitioners of RPO unless revoked by written request.

*X*____ _____________________

Patient/Guardian Signature **Date**

INSURANCE INFORMATION *(Please complete this section & hand your card(s) to the receptionist.)*

Policy Holder Name: SELF ☐ or OTHER ____

Policyholder Date of Birth: ______________________ Relationship to Patient: ______________________

Pediatric Patients: Is your child enrolled in TN Early Intervention Services? ________ ID#: __________________

SECONDARY INSURANCE INFORMATION

Policy Holder Name: SELF ☐ or OTHER ____

Policyholder Date of Birth: ______________________ Relationship to Patient: ______________________

WORKERS COMPENSATION / LIABILITY INSURANCE ****MVA / LIABILITY CLAIMS – Please be advised that you are responsible for payment of all services; Payment cannot be withheld pending a settlement of your claim.***

Claim Number: _________________ Date of Injury: ____-_____-_____Place of Injury: _____________________

Employer at Time of Injury: _______________________________ Employer Phone #: ____________________

Claim Adjuster: ____ Phone #: _____________________________

MEDICAL INFORMATION *(Please Complete this Section Fully)*

Referring Physician: _____________________________________ Phone #: _______________________________

Primary Care Physician: __________________________________ Phone #: _______________________________

Were you injured in an automobile accident?	YES ☐	NO ☐
Is your condition due to a work-related injury?	YES ☐	NO ☐
Have you had a brace or artificial limb in the past 5 years?	YES ☐	NO ☐
Do you have a latex / neoprene allergy?	YES ☐	NO ☐
Are you Diabetic?	YES ☐	NO ☐

If Yes, please list diabetic treating physician: __________________________Phone #: ______________________

PROSTHETIC PATIENTS: Left ☐ Right ☐ Below Knee ☐ Above Knee ☐ Upper Extremity ☐

Date of Amputation: _____________________

MEDICAL HISTORY: Height: _____ft. _____in. Weight: ________lbs.

Are you currently residing in a nursing home/or are you going to be residing in a nursing facility within the next 30 days: Yes No If yes, Facility Name: ___________________________

Activity level: ____Low ____Medium ____High ____Highly active

How would you describe your general health? ____Poor ____Fair ____Good ____Excellent

Do you have any contact precautions or communicable disease our staff should be aware of: Yes No

(For example: MRSA, Staph, Strep A, etc.)? If yes, explain: ____

Attending Therapy? ____Physical ____Occupational ____Both

Therapist: ____________________________________ Phone: ____