



**PATIENT INFORMATION**

*(Please Print All Information)*

Date: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Text Messaging:  Yes  No

Patient Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Birth Date: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

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

Height: \_\_\_\_ ft. \_\_\_\_ in. Weight: \_\_\_\_ lbs.

Living Situation:  Alone With Assistance  Alone Without Assistance  With Others with Assistance  With Others Without Assistance  Long Term Care Facility  Other: \_\_\_\_\_

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Emergency Contacts: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Can we release your Protected Health Information (PHI) to emergency contact? YES  NO

**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: \_\_\_\_\_

**SECONDARY INSURANCE INFORMATION**

Policy Holder Name: SELF  or OTHER \_\_\_\_\_

Policyholder Date of Birth: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**TERTIARY INSURANCE INFORMATION**

Policy Holder Name: SELF  or OTHER \_\_\_\_\_

Policyholder Date of Birth: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**WORKERS COMPENSATION / LIABILITY INSURANCE**

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 #: \_\_\_\_\_

Attending Therapy?  Physical  Occupational  Both

Physical Therapist: \_\_\_\_\_ Phone #: \_\_\_\_\_

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: \_\_\_\_\_

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

Do you use tobacco? YES  NO

Are you Diabetic? YES  NO

Have you experienced any of the following?

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Alzheimer's or Dementia | <input type="checkbox"/> Anxiety               | <input type="checkbox"/> Asthma              |
| <input type="checkbox"/> Brain Injury/TBI        | <input type="checkbox"/> Cancer                | <input type="checkbox"/> Depression          |
| <input type="checkbox"/> Diabetes Type I         | <input type="checkbox"/> Diabetes Type II      | <input type="checkbox"/> Hearing Loss        |
| <input type="checkbox"/> Heart Problems          | <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> HIV                     | <input type="checkbox"/> Infections            | <input type="checkbox"/> Intestinal Problems |
| <input type="checkbox"/> Kidney Disease          | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Migraines           |
| <input type="checkbox"/> MRSA                    | <input type="checkbox"/> Neurological Problems | <input type="checkbox"/> Obesity             |
| <input type="checkbox"/> Osteoarthritis          | <input type="checkbox"/> Osteoporosis          | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Pulmonary Disease (TB)  | <input type="checkbox"/> Rheumatoid Arthritis  | <input type="checkbox"/> Seizure Disorders   |
| <input type="checkbox"/> Skin Problem            | <input type="checkbox"/> Stomach Problem       | <input type="checkbox"/> Stroke/TIA/CVA      |
| <input type="checkbox"/> Vascular Disease        | <input type="checkbox"/> Vision Problems       |  |

Other conditions: \_\_\_\_\_

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

Date of Amputation: \_\_\_\_\_

Have you received any orthotic/prosthetic items, such as plastic or metal bracing, ankle splints, walking boot, back braces, knee braces, etc., within the last 5 years?  Yes  No

Date Received: \_\_\_\_\_ Who supplied the item? \_\_\_\_\_

Why do you no longer use? \_\_\_\_\_

Activity level:  Low  Medium  High  Highly active

How would you describe your general health?  Poor  Fair  Good  Excellent

**PHOTO RELEASE FORM FOR ADULTS AND/OR MINORS (IF UNDER 18)**

Restorative Health Services d/b/a Restorative Prosthetics & Orthotics has my permission to use my or my child’s photograph. By consenting to photographs and/or video images I understand that no royalty, fee or other compensation shall become payable to me by reason of such use. I further acknowledge that my participation is voluntary and agree that use of any photographs and/or video images confers no rights of ownership or royalties whatsoever.

I authorize the use of photographs and/or video images; (please initial indication YES or NO below)

\_\_\_\_\_ YES \_\_\_\_\_ NO For educations purposes (medical teaching or teaching or training),

\_\_\_\_\_ YES \_\_\_\_\_ NO Form marketing and advertising purposes (website, print, digital, or social media),

\_\_\_\_\_ YES \_\_\_\_\_ NO At my request, my photographs and/or video images will only be used as part of my medical record.

If I wish to withdraw my consent in the future, I may do so via written request submitted to Restorative Health Services d/b/a Restorative Prosthetics & Orthotics completion of a new form.

**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. RPO does not offer rental DME for Prosthetic and Orthotic devices to their patients.

**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 Health Services, Inc. d/b/a Restorative Prosthetics & Orthotics 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 SEOP 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.

## **PATIENT'S RIGHTS**

Patients have the right to:

- Receive quality medical care regardless of race, color, sex, national origin, diagnosis, disability, political affiliation, sexual orientation or preference, veteran status, religion, gender, age, ability to pay, or conditions of reimbursement.
- Receive compassionate care that respects their personal, spiritual, cultural, and religious values and beliefs.
- Participate in resolution of ethical dilemmas about patient care decisions. Resources to facilitate resolution of ethical issues are available for patients and their families.
- Know the name and role of their attending physician and any other caregiver(s) participating in their care. • Request that an individual of his/her choice, family member or otherwise, and/or a physician of his/her choice be notified in the event that he/she is admitted to the hospital.
- Be well-informed about his/her illness, possible treatments and likely outcomes and to discuss this information with his/her physician in a manner which the patient can understand.
- Receive information about any proposed treatment or procedure in order to make an informed decision whether to consent to or refuse a course of treatment. Except in emergencies, this information shall include the purpose and description of the procedure, probable result, significant risks, and alternate courses of treatment.
- Actively participate in decisions regarding medical care, including managing pain effectively. To the extent permitted by law, this includes the right to refuse treatment after being informed of the consequences of refusal, the right to leave the care of the entity against physician's advice, except in extraordinary circumstances, or both.
- Be free from restraints and seclusion except where necessary for medical treatment or patient safety, or where required by law. Restraints and seclusion are not to be used for coercion, discipline, convenience, or retaliation. If the patient has any question regarding the use of restraints, he/she should feel free to ask his/her care nurse or physician.
- Privacy and confidential treatment of all communications and records about his/her care. Release of medical records will only occur with the patient's consent or where permitted by law. While a patient, he/ she may examine his/her medical record with a healthcare provider designated by the entity, except to the extent that such review is determined by the patient's attending physician to be potentially harmful to the health of the patient. Fulfillment of patient requests to review and/or receive a copy of his/her medical record will occur in a timely manner.
- Accept or decline participation in research. Participation is voluntary and will only occur after a full explanation has been given and written permission has been obtained. The patient's decision not to participate in research or to discontinue participation at any time will not result in any penalty, loss of benefits, or loss of access to care to which the patient is otherwise entitled.
- Be informed of entity policies that affect care and treatment.
- Be informed about charges, professional fees and payment arrangements. Restorative Prosthetics & Orthotics will not deny medically necessary care based on payer issues. Should any dispute occur regarding third party coverage, Restorative Prosthetics & Orthotics will keep the patient and/or guardian informed.
- Know if the entity has relationships with outside parties that may influence the patient's treatment or care. These relationships may be with education institutions, other healthcare providers, or insurers. • Access protective services that are independent of Restorative Prosthetics & Orthotics, if the patient and/or family have a concern about patient abuse, neglect, or misuse of a patient's property while in the care of an Restorative Prosthetics & Orthotics
- Be informed of realistic care alternatives and continuing care requirement when the current level of care is no longer appropriate. Alternatives include ambulatory, home care, inpatient, or outpatient care of transfers to another setting. If transfer is recommended or requested, the patient will be informed of the risks, benefits, and alternatives. The patient will not be transferred until another institution and/or provider agrees to accept the patient.

- Receive information concerning advance directives such as a living will and healthcare power of attorney. These documents express the patient’s choices for treatment or designate someone to represent the patient in the event the patient is unable to communicate his or her wishes. The advance directive will be respected to the extent permitted by law.
- Receive information describing the patient’s rights and responsibilities and the complaint resolution process for the entity.

**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.

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Patient/Guardian Signature

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Date