Patient's Last Name: ______________________ **First Name**: ____________________ **Middle Initial**: _____

Date Of Birth: ____ /____ / ______ Gender: M ___ F ___ **Pronoun: __________ SSN: _____ -_____ -______**

Email: _______________________ **Employment**: F/T ___ P/T___ Student ___ Unemployed ___On Disability ___

Driver's License: ______________________ **Marital Status**: S ___ M ___ D ___ W ___ Other (specify): ______

Home PH: (____) ______ - _______ **Cell PH**: (____) ______ - _______ **Work PH**: (____) ______ - _______

Home Address: ____

Mailing Address: (*if different than home address*):____

*****OPTIONAL INFO TO COMPLETE:*** **Race:** ___American Indian/Alaskan Native ___Native Hawaiian/Other Pacific Islander ___Asian ___White ___Black or African American ___Other	**Education:** ___Some High School ___High School/GED ___Some College/Tech Degree ___College Degree ___Graduate Degree	**Hispanic/ Latino:** __Yes __No **Armed Forces:** __Active Service Member __Reserve Service Member __Veteran __Not a member

Emergency Contact: ____________________ Relationship: ______________ **PH**: (____) ______ - _______

Prescribing DR: ______________________ **PH**: (____) ______- _______ **FX**: (____) ______ - _______

Primary Care DR: _____________________ **PH**: (____) ______- _______ **FX**: (____) ______ - _______

How did you hear about us?: ____

PRIMARY INSURANCE: **Company Name**: ___________________________________

ID #: ________________ **Group #**: ________**Subscriber's Employer**: __________________________

Relationship to Subscriber: Self ___Spouse___ Dependent ___ Other___ *****If SELF is Checked, SKIP to next question***

Subscriber's Name: ___________________________ Subscriber's Date of Birth: _____/ _____/ ________

Subscriber's Gender: M ___ F___ Subscriber's SSN: _____ -_____ -______ Ph: (____) ______ - _______

Address (if different): ____

SECONDARY INSURANCE: NO ___ YES ___ Company Name: ___________________________________

ID #: ________________ **Group #**: ________**Subscriber's Employer**: __________________________

Relationship to Subscriber: Self ___Spouse___ Dependent ___ Other___

Subscriber's Name: ___________________________ Subscriber's Date of Birth: _____/ _____/ ________

Subscriber's Gender: M ___ F___ Subscriber's SSN: _____ -_____ -______ Ph: (____) ______ - _______

Address (if different): ____

WORKERS COMPENSATION: NO ___ YES ___ Claim #: _________________ **Injury Date**: _____/ _____/ _____

Carrier Name: ________________________________ **Adjusters Name**: __________________

Claims Address: ____

Claims PH: (____) ______ - _______ **Attorney**: ____________________ **PH:** (____) ______ - _______

Form Completed By: ______________________ **Relationship**: _____________ **Date**:__________

PATIENT MEDICAL PROFILE/HISTORY

Name: ____ **Date:** ___________________

Height: _______ **Weight:** _______ lbs **Shoe Size:** _____ **Side Affected:** ____RIGHT ____LEFT ____BOTH

Tobacco Use?: ____Currently ____Quit ____Never **Type**: _______________________

Falls in last 6 Mo? ____YES ____NO If Yes: **How many**? _____ **Were you hospitalized**? ____YES ____NO

Hospital, ER, or Urgent Care in last 6 Mo? ____YES ____NO **Details**: _____________________________

General Health: ____POOR ____FAIR ____GOOD____EXCELLENT

Your Activity Level: ____SEDENTARY____LIMITED ACTIVITY____ACTIVE____VERY ACTIVE

PLEASE CHECK ALL THAT APPLY:

____ Accident from Employment Date of Accident: ___________________

____ Auto Accident State Accident Occurred: _____________

____ Other Type of Accident County Accident Occurred: ___________

____ Condition Since Birth If Accident Describe: ____________________________________

____

Have you received a device in the past 5 years? ____YES ____NO **If so, please provide details:**

____

List any other conditions that you feel might affect your treatment:

____

List Medications: ____

____

Amputations? ____YES ____NO **Level**: _____________________________

Reason: ____**Date**:___________

Allergies? ____YES ____NO **Detail:** __________________________________

Pain Medication? ____YES ____NO ______________________Med ______Dosage _______Freq

Major Surgeries? ____YES ____NO **List Surgery & Year:** ________________________________

____

DO YOU HAVE OR HAVE YOU HAD THE FOLLOWING?

☐ Alzheimers or Dementia	☐ High Blood Pressure	☐ Osteoporosis
☐ Anxiety	☐ HIV	☐ Parkinson's Disease
☐ Asthma	☐ Infections	☐ Pulmonary Disease (TB)
☐ Brain Injury/TBI	☐ Intestinal Problems	☐ Rheumatoid Arthritis
☐ Cancer	☐ Kidney Disease	☐ Seizure Disorders
☐ Depression	☐ Liver Disease	☐ Skin Problems
☐ Diabetes Type I	☐ Migraines	☐ Stomach Problems
☐ Diabetes Type II	☐ MRSA	☐ Stroke/TIA/CVA
☐ Hearing Loss	☐ Neurological Problems	☐ Vascular Disease
☐ Heart Problems	☐ Obesity	☐ Vision Problems
☐ Hepatitis **Circle**: A B C	☐ Osteoarthritis	

☐ Alcoholism	☐ Joint Replacement
☐ Currently Pregnant	☐ Pacemaker
☐ Incontinence	☐ Scoliosis

Orthopedic, Plastic or Other Surgeon: ______________________________

Group Practice Name:

____

Phone #: ______________ Fax: ______________ Last seen: ______________

Occupational Therapist or Physical Therapist: ______________________________

Group Practice Name:

____

Phone #: ______________ Fax: ______________ Last seen: ______________

LIST CHANGES: ______________________________

____

Last Reviewed by Patient Date(s): ___/___/___ ___/___/___

Prosthetic & Orthotic Associates, Inc.
Handspring Clinical Services

Patient's Name: ___________________________________

Acknowledged Receipt of Notice of Privacy Practices

I, the undersigned, certify that I have received a copy of Prosthetic & Orthotic Associates, Inc./Handspring Clinical Services' Notice of Privacy Practices. The Notice describes the types of use and disclosure of my protected health information that might occur in my treatment, payment of my claim, or in the performance of POA/Handspring's health care operations. The Notice of Privacy Practices also describes my rights and POA/Handspring's duties with respect to my protected health information. The Notice of Privacy Practices is posted in each perspective office, and we reserve the right to change the privacy practices that are described within. I may obtain a revised Notice of Privacy Practices by requesting a copy be sent in the mail or asking for one at the time of my appointment. **Initials _____**

OPTIONAL

I give my permission to leave a ***detailed message*** at the following phone number(s):

Home: (_____)________________ Cell: (_____)________________ Other: (_____)________________ Specify Type: __________

I give my permission to receive ***text messages*** at the following phone number(s):

Cell: (_____)__________________ *(Relationship: ______________)* Cell: (_____)________________ *(Relationship: ______________)*

I understand that text message communications may be unsecured and therefore the potential that the communication could be read by a third party. I understand my mobile provider's standard rates for sending and receiving text messages will apply.

Initials _____

Family & Friends Release

The name(s) listed below are family members or friends to whom I wish to grant access to my personal health care information (PHI). I will rely on the professional judgement of my provider and his/her designee to share such information, as they deem necessary. I understand that information is limited to verbal discussions and that no paper copies of my PHI information will be provided without additional consent to release any sensitive information

Name: ___________________________ Relationship: ______________ Phone: _____________________ Home? ____ Cell? ____

Name: ___________________________ Relationship: ______________ Phone: _____________________ Home? ____ Cell? ____

These consents will be considered valid until such time that I revoke them, and I reserve the right to revoke them at any time. It will be my responsibility to keep this information up to date. **Initials _____**

Medicare DMEPOS Supplier Standards (*For Beneficiaries only*)

I have been provided a copy of the Medicare DMEPOS Supplier Standards. **Initials _____**

Acknowledged Receipt of Patient Financial Policy

I certify that the insurance coverage listed on the registration form is accurate to the best of my knowledge and have received a copy of POA/Handspring's financial policy. I understand that I am financially responsible for any amount not covered by my insurance contract. **Initials _____**

Billing Authorization

I, the undersigned, authorize the release of any medical or other information necessary to process the claim. I request payment of commercial and/or government health insurance benefits be assigned to POA/Handspring. I authorize the use of this signature on all my insurance claim submissions.

_______________________________________ _______________________

Patient /Legal Guardian/Authorized Person's Signature Date

_______________________________________ _______________________________________

Printed Name of Guardian/ Authorized Person Relationship to Patient / Description of Authority

POA / HANDSPRING PATIENT FINANCIAL POLICY

We are committed to building a successful relationship with you and your family. As such, your clear understanding of our Patient Financial Policy is important to our professional relationship and payment for services is a part of that relationship. It is your responsibility to notify our office of any patient or insurance information changes.

Coinsurance & Deductible
All coinsurance amounts and past due balances, are due at the time services are rendered, unless previous arrangements have been made with administrative staff. We accept cash, check or credit cards. No post-dated checks will be accepted.

Insurance Claims
Insurance is a contract between you and your insurance company, and we bill them as a courtesy to you. To bill properly, we require that you disclose all insurance information including primary and secondary insurance, as well as any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network with your insurance company, and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

To ensure a smooth claims process, please avoid making any changes to your insurance coverage during the fitting and fabrication of your device. The date of service for your claim will be the date your device is delivered.

If your insurance plan is one with which we are not a participating provider, you will be responsible for payment in full at the time of delivery unless other arrangements have been made with administrative staff. As a courtesy, we will file your initial insurance claim.

Minors
The parent(s) or guardian(s) is/are responsible for full payment and will receive the billing statements. A signed release to treat may be required for unaccompanied minors.

Motor Vehicle Accident (MVA) & Third-Party Billing
Since our relationship is with you and not with the third-party liability insurance (auto, homeowner, etc.), we will not be submitting a claim on your behalf. It is your responsibility to seek reimbursement from the liability insurance. However, at your request, we will submit a claim to your primary health insurance carrier. You may receive an accident questionnaire from your health insurance to be completed by you. If the questionnaire is not returned to your health insurance company and/or we receive a denial on your claim, you will be responsible for payment in full.

Outstanding Balance Policy
Our office policy requires that all patients receive routine statements. If payment is not received within a reasonable time, we will attempt to arrange a payment plan. If no resolution is reached, the account may be referred to a collection agency. This could result in discharge from our practice. The person responsible for the account will be liable for all collection costs, including attorney fees and court costs.

POA / HANDSPRING PATIENT FINANCIAL POLICY

Refunds
We do our best to estimate your deductible and coinsurance before you receive your device. However, there may be discrepancies during the processing of our claim. Any overpayment will be credited to your account. Please contact our billing department if a refund is preferred.

When a custom fabricated device is prescribed by the physician and made to fit you, it cannot be returned for credit or refund. Prescribed prefabricated items cannot be returned for credit or refund due to hygienic concerns.

Returned Checks
The charge for a returned check is $35 payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash-only basis following any returned check.

Self-pay Accounts
Self-pay accounts include when patients have no insurance coverage, patients are covered by insurance plans in which the office does not participate and liability cases. We do not accept attorney letters or contingency payments. Extended payment arrangements may be considered on an individual basis. Please ask the office administrative staff to discuss a mutually agreeable payment plan. It is never our intention to cause hardship to our patients, only to provide them with the best care possible and the least amount of stress.

Workers' Compensation
It is the patient's responsibility to provide our office staff with claims adjuster and/or attorney contact information regarding a workers' compensation claim. If the claim is denied by the workers' compensation insurance carrier, it then becomes the patient's financial responsibility. At your request, we will submit the claim to your primary medical insurance carrier with a copy of the workers' compensation insurance denial. If your primary medical insurance carrier's claim is denied, you will be responsible for payment in full.

This financial policy helps the office provide quality care to our valued patients. If you have any questions or need clarification of any of the above policies, please feel free to contact us at POA/Handspring, 4 Riverside Drive, Middletown, NY 10941 or (845) 956-0001

Prosthetic & Orthotic Associates, Inc.
Handspring Clinical Services

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Date: _________________

Patient Name: ________________________________ Date of Birth: _________________

Address: ____

I, the undersigned, do hereby grant permission for Prosthetic & Orthotic Associates Inc./Handspring Clinical Service to:

- obtain from:
- release to:

Name of person or institution: ____

Address of person or Institution: ____

The following information from the patient's clinical record:

____

Mail: **Prosthetic & Orthotic Associates Inc./Handspring Clinical Services**
4 Riverside Drive
Middletown, NY 10941
Or Fax : Middletown (845) 344-6829 / Kingston (845) 339-4793 / Poughkeepsie (845) 454-1621

I understand that this information will be used for the purpose of:

- Providing information to allow care to be provided to the patient
- Providing information to the physician regarding the care provided by the orthotist/prosthetist
- Supporting the payment of an insurance claim
- Other: ____

This authorization will be valid for the period of twelve months from the date of signature, unless otherwise

specified here: __________________

____ ___________________________
Patient, Legal Guardian, Authorized Person's Signature Date

____ ____
Printed Name of Guardian/ Authorized Person Relationship to Patient / Description of Authority

RELEASE FOR MEDIA AND PROMOTIONAL USE OF LIKENESS

I understand that Prosthetic & Orthotic Associates (and herein referred to as POA)/ Handspring, its employees and agents, and anyone under the supervision, direction and instruction of POA/Handspring, and their employees and agents, including any print, video, audio, or electronic media may take photographs, video, audiotapes and other images and sound media of me as it relates to my amputation(s) and/or my evaluation, training and fitting for, and use of, any POA/Handspring device. POA/Handspring may wish to use such photographs for news media, educational, promotional, advertising, and other purposes, or to share with manufacturers.

This permission for release, without compensation or prior notice, would allow POA/Handspring to use photographs in its printed publications, during presentations, and otherwise. I freely and voluntarily consent to the use and publication of my name, pictures of my evaluation intended to benefit me and others in need to these devices, pictures, and/or likeness by POA/Handspring for any and all purposes including, but not limited to; educational, promotional, advertising, trade and news media; through any medium or format, including, but not limited to; videotape, audiotape, film, photograph, television, radio, digital, internet, theatre, or any other source at any time from this date forward until I revoke this consent in writing. I further waive any claims against POA/Handspring and its employees and agents and anyone acting at the request of POA/Handspring based upon or related to its use or publication of my likeness, voice, participation and/picture. I freely give this authorization without remuneration but with the hope of helping others in need, gain access to POA/Handspring.

Please initial one and note any further limitations by checking boxes below:

_____I give my permission to use my full likeness, including my face, hands, arms, shoulders, torso, legs and feet (as described in the Release For Media and Promotional Use of (my) Likeness EXCEPT as follows (check all exceptions that apply):

- ☐ I give this authorization without limitation;
- ☐ No release of my name;
- ☐ No release to the news media;
- ☐ No release for educational purposes of other patients;
- ☐ No release for educational purposes of practitioners and students;
- ☐ No release for educational purposes of manufacturers;
- ☐ No release for POA/Handspring promotional or advertising purposes regardless of the form of the publication.

_____I limit my permission to use my likeness to portray ONLY my hands, arms, shoulders, torso, legs and feet (EXCLUDING my face) as described in the Release For Media and Promotional Use of (my) Likeness EXCEPT as follows (check all exceptions that apply):

- ☐ I give this authorization without limitation;
- ☐ No release of my name;
- ☐ No release to the news media;
- ☐ No release for educational purposes of other patients;
- ☐ No release for educational purposes of practitioners and students;
- ☐ No release for educational purposes of manufacturers;
- ☐ No release of visuals of my likeness, only audio recording permitted;
- ☐ No release for POA/Handspring promotional or advertising purposes regardless of the form of the publication.

I understand that POA/Handspring may contact me to request my permission at some later date to use my likeness for any purpose that I may have refused to give permission at this time. I also understand that if I give my permission now that my permission is irrevocable after my likeness has been published and/or distributed at any time after my permission is given and before my permission is revoked in writing.

Furthermore, I understand that it is unlikely, but possible that my likeness could enter the public domain through the media and could be re-released and used without my authorization by others outside the control of POA. POA will take reasonable precautions to help prevent this from happening.

Please check one:

_____I am over the age of eighteen years, and I have read the foregoing and fully and completely understand the contents.

_____I represent that the subject of the photographs is a minor and that I am the parent of the minor and that I have read the foregoing and fully and completely understand the contents.

To revoke this consent, please contact in POA/Handspring at 4 Riverside Drive, Middletown, NY 10941.

______________________________	______________________________	_____________
Patient Name	*Patient Signature*	*Date*
______________________________	______________________________	_____________
Guardian Name	*Guardian Signature*	*Date*

____ ______________

POA staff signature and title *Date*

Signatures are digitally captured in OPIE Facility Documents Management