General Patient Information

First Name _____ **Middle Name** _____ **Last Name** _____ **Preferred Name** _____

Date of Birth ___/___/_____ ***Gender*** ☐ Male ☐ Female

Social Security Number _____ - _____ - _____

E-mail Address _____

Driver's License Number _____ **Preferred Language** _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other _____

****Please select your preferred contact phone number.***

☐ **Home Phone** _____ ☐ **Mobile Phone** _____

☐ **Work Phone** _____

Home Address: _____

OTHER Patient Information

What is your ethnicity? Please choose one:

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ I prefer not to answer

What is your race? Please check any that apply:

☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander

☐ Asian ☐ White ☐ Black or African American ☐ Other ☐ I prefer not to answer

Patient Contacts

RESPONSIBLE PARTY ☐ Patient ☐ Other If other, please complete this section:

Name _____ **E-mail Address** _____

Relationship to Patient ☐ Parent ☐ Guardian ☐ Other _____

Home Phone _____ **Mobile Phone** _____

Work Phone _____

Home Address

_____

EMERGENCY CONTACT

☐ Same as Responsible ☐ Other If other, please complete this section:

Name _____ **Relationship to Patient** _____

Home Phone _____ **Mobile Phone** _____

Work Phone _____

Home Address _____

_____ ☐ Address Same as Patient

City _____ **State** _____ **Zip Code** _____

Insurance Information

Is this a workman's compensation case? ☐ Yes ☐ No

Case Manager's Name / Case ID # _____ **Phone Number** _____

PRIMARY INSURANCE COMPANY

Ins: Name _____

ID Number _____ **Group Number** _____

Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other _____

If patient is not the subscriber, please complete the subscriber information section below.

SECONDARY INSURANCE COMPANY

Ins: Name _____

ID Number _____ **Group Number** _____

Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other _____

SUBSCRIBER INFORMATION

Name: _____ **DOB:** _____

Social Security Number _____ - _____ - _____

Home Phone _____ **Mobile Phone** _____

Work Phone _____

Please check all that apply:

☐ Your condition is a result of an accident from employment
☐ Your condition is a result of an auto accident
☐ Your condition is a result of any other type of accident
☐ I have had this condition since birth

If your condition is the result of an accident or injury, fill the following details:

Date of accident/injury ____ / ____ / _____ **Where it happened** _____

Description of accident/injury: _____

Have you received any orthotics or prosthetic device(s) within the past five years? ☐ Yes ☐ No **If yes, please list item(s) and date:**

Brace It Orthotics and Prosthetics

Request for Medical Records/Documentation

Patient Name: _____ **DOB**: _____

Dear: _____

This letter will authorize you to provide a copy, summary, or narrative of my medical records (as indicated by the check mark(s) below) or to otherwise release confidential information. At this time, I am requesting the following:

_____ Compete Record

_____ Records of care from _____ to _____ only

_____ Records Of care concerning the following condition

_____

_____ Other. Please Specify _____

The following person(s)

Brace It Orthotics and Prosthetics
3170 W Sahara Ave #150
Las Vegas, NV 89102

Phone: 702-478-5848
Fax: 702-478-5565

The reason or purpose for this release of information are:

_____

Signed: _____ Date: _____
(Patient or person legally authorized to consent on patient's behalf)

Warranty Policy:

This Warranty period for custom / premade Orthotics and Prosthetics is 3 months for workmanship and materials. Needed adjustments and repairs within the warranty period will be done at no charge. There will be a separate charge for adjustments on repairs that are made as a result of physiological changes or undue rough wear and tear. After the 3-month warranty period, repair work for normal wear of leather, liners or any additional adjustments prescribed by a physician will be charge fee small adjustments fee's will be determined by the practitioner.

Infrequent or non-use of device, or failure to contact the treating practitioner, does not absolve the patient, insurance company, hospital, or nursing home from responsibility for payment. Since the device is prescribed by a physician and rendered, it cannot be returned for credit on the account.

It is in your best interest to communicate with your practitioner in a timely manner to allow us to resolve any problems or issues that you are experiencing as quickly and efficiently as possible. It is our goal at Brace-It Orthotics and Prosthetics to provide you with the best care possible, and we will make every attempt to satisfy your needs. Please contact us if you have any questions or comments.

Financial Policy:

Brace It Orthotics and Prosthetics verifies all insurance prior to time of your visit. Prior authorization (or the need for it) is verified and obtained prior to making or delivery of any item we furnish to you. Every attempt is made to furnish you with an estimate of your cost should you be responsible for any deductible and/or co-pays. This will be due and payable in full at the time the item is delivered.

CASH PAY patients are required to put 50% down on any item (orthotic, orthosis or prosthetic device) before we order any supplies or begin to make any device. The remaining balance is due at time of delivery.

Your insurance carrier may advise us that PRIOR AUTHORIZATION IS NOT A GAURANTEE OF PAYMENT. Should your insurance carrier choose not to pay us, you will be held responsible for 100% of the billed charges. Our office will make every attempt to get your insurance carrier to pay for your items before we submit the bill to you. If it is determined that the insurance company will not pay for the item(s), you agree to accept responsibility for payment for the item(s) that you have receive. Payment will be due and payable 30 days after you receive your statement. As a courtesy, we will bill your primary insurance carrier for you after verification of covered services. We will withhold action for 60 days, but if your insurance carrier has failed to pay within 60-day period, we will expect you to pay the balance of your bill in full immediately. You may then seek reimbursement/appeal from your insurance company. We will bill your secondary insurance carrier once the primary has paid.

Once a custom item has been made for you or a custom measure item ordered for you, it cannot be returned to the manufacture nor can we take it back for use on another patient. We will bill your insurance carrier for these items and hold your responsible for any outstanding balances, whether or not the item(s) have been received by you.

Once a statement is sent to you, failure to contact us or clear the balance within 60 days may result in further legal action. If this occurs, your account is subject to additional charges of $75.00, from our collection agency, as well as additional monthly interest charges.

Returned Check: A $35.00 fee will be applied.

I understand that once Brace It Orthotics and Prosthetics releases my account to any collection agency I am responsible for the entire outstanding balance, including penalties/interest and collection agency fees even if my insurance carrier pays Brace It Orthotics and Prosthetics or the Collection agency after the account is turned over to them.

Refund Policy:

Custom Made items are specifically for your needs according to your doctor's orders. Once a custom-made item is ordered for you, you and/or your insurance will be billed for the item(s). Once the item is ordered for you, it cannot be returned, and refunds will not be issued, as this item was specifically fabricated for you and can't be used to a different patient. Premade item(s) won't be returned after taking delivery of the device(s) as this violates health codes and is unsanitary.

Every effort is made before you leave the office to ensure that the item(s) are as prescribed and that you can put them on and off correctly, the item(s) should be comfortable and tolerable to wear once you break in the device(s) as instructed by your practitioner.

****By signing below, you agree and understand the above company policies and agree by the terms indicated.***

_____
Printed Patient Name

_____ _____
Patient's Signature Today's Date

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby certify that I have received a copy of the “Notice of Privacy Practices” *upon request of patient* which describes how Brace It Orthotics and Prosthetics may disclose my protected health information, will be used and disclosed in carrying out my treatment, collection of my bills, or health care operations and for other purposes that are permitted or required by law. It also describes my rights to access and control of my protected health information. My “protected health information” means any of my written and oral health information, including demographic data that can be used to identify me. This is health information that is created or received by Brace It Orthotics and Prosthetics and that relates to my past, present or future physical or mental health or condition.

Brace It Orthotics and Prosthetics reserves the right to change the privacy practices that are described in its Notice of Privacy Practices. Brace It Orthotics and Prosthetics also reserve the right to apply these changes retroactively to PHI received before the change in privacy practices. I understand that I may obtain a revised Notice of Privacy Practices by calling Brace It Orthotics and Prosthetics at 702-478-5848 and requesting a revised copy will be sent in the mail or by asking for one at the time of my next appointment.

_____

Signature of Patient or Parent/Guardian/Caregiver

_____

Name of Patient or Parent/Guardian/Caregiver

_____

Date