Thompson's Custom Orthotics and Prosthetics

401 S. Sherman St	601 S. 5th Ave #302	717 6th Street
Spokane, WA 99202	Spokane, WA 99204	Clarkston, WA 99402
(509) 624-1308	(509) 455-7037	(509) 758-8874

PATIENT INFORMATION

Full Name: _____ Date of Birth: _____Male ☐ Female☐
Address: _____ City: _____ State: _____ Zip code: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Marital Status: M ☐ S ☐ D ☐W☐ Social Security Number_____
Parents/Caregiver **(if applicable)**: _____ Relationship: _____Phone:_____
Emergency Contact: _____ Phone: _____ Relationship: _____

PRIMARY INSURANCE INFORMATION

Name of Insurance _____Policy Number _____Group Number_____
Policyholder Name _____ Relationship to Patient _____DOB policyholder_____

SECONDARY INSURANCE INFORMATION

Name of Insurance _____Policy Number _____Group Number_____
Policyholder Name: _____ Relationship to Patient: _____DOB Policyholder_____

PHYSICIAN INFORMATION

Prescribing Physician/Clinic_____
Primary Care Physician _____

MEDICAL INFORMATION

Reason for Visit _____ Right ☐ Left ☐ Date of Injury: _____

Is/was surgery scheduled? Yes☐ No☐ If yes, Date of Surgery_____ Location: _____
Name of surgeon: _____

Are you currently an in-patient at a Nursing Home or Skilled Nursing Facility? Yes ☐ No ☐
If yes, Where _____ Phone: _____
Do you attend physical therapy? Yes ☐ No ☐
If yes, Where _____Therapist_____Phone_____

Are you diabetic? Yes ☐ No ☐ if yes, are you Insulin Dependent? Yes ☐ No ☐
If you are a Diabetic, what is your physician's name who treats you for this condition? _____

Is this a work related injury? Yes ☐ No ☐ if yes, Employer Name: _____
Date of Injury_____ Claim Number_____
Is this an injury related to a Motor Vehicle Accident? Yes ☐ No ☐ Claim Number_____

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PRIVATE INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE

I authorize payment of medical benefits to Thompsons Custom Orthotics and Prosthetics for any services furnished to me (or to the patient for whom I am the responsible party) by the Practitioners. I understand that I am financially responsible for any amount not covered by my contract. I authorize you to release to my insurance company information concerning health care, advice, treatment, or supplies provided to the patient. I understand that I am financially responsible for services provided to me if I am uninsured. I am also responsible for any product or service that is not covered by a Labor and Industries claim, third party claim, and or auto insurance claim.

MEDICARE LIFETIME SIGNATURE ON FILE

I request that payment of authorized Medicare benefits be made on my behalf to Thompsons Custom Orthotics and Prosthetics for any services provided to me by the Practitioners. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits payable for related services.

MEDICARE DMEPOS SUPPLIER STANDARDS

The products and /or services provided to you by Thompson's Custom Orthotics and Prosthetics are subject to the supplier standards contained in the Federal regulations shown at 42 Code of Federal Regulations Section 424.57(c). These standards concern business professional and operational matters (e.g. honoring warranties and hours of operation). The full text of these standards can be obtained at http://ecfr.gpoaccess.gov. Upon request we will furnish you a written copy of the standards.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I certify that I have received a copy of Thompsons Custom Orthotics and Prosthetics 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 bills, or in the performance of Thompsons Custom Orthotics and Prosthetics health care operations. The Notice of Privacy Practices also describes my rights and Thompsons duties with respect to my protected health information. The Notice of Privacy Practices is posted in the front office.

Thompsons Custom Orthotics and Prosthetics reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised copy of said Privacy Practices by calling the office and requesting a revised copy be sent to me in the mail or by asking for one at the time of my next appointment.
If you have any questions about this Notice please contact: Darla Anderson our Privacy Officer at (509) 624-1308

FRIENDS AND FAMILY PERSONAL HEALTH RELEASE

The names listed below are family members or friends to whom I wish to grant access to my health care information. I will rely on the professional judgment 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 my signature to release any "sensitive" information.
The consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time.
It will be my responsibility to keep this information up to date, as I recognize that relationships change over time.

Name:_____ Relationship: _____Phone:_____

Name:_____ Relationship:_____ Phone:_____

X_____
Patient/Guardian/Responsible Party Signature Date

X_____
Patient/Guardian/Responsible Party Signature (All Information Current) Date

X_____
Patient/Guardian/Responsible Party Signature (All Information Current) Date

(This authorization will expire one year from the date it is signed. You have the right to revoke an authorization at any time with written request.)

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PATIENTS RIGHTS AND WARRANTY POLICY

Needed adjustments or repairs within the warranty period will be done at no charge. The warranty period for custom Orthotics and Prosthetics is three months (90 days) for workmanship and materials. However, during this three month period there will be a separate charge for adjustments or repairs that are made as a result of abuse or undue rough wear and any adjustments or additions which are prescribed by a physician and not part of the original order. We honor all manufactures warranties and will notify you of the warranty coverage on the separate components of the device (i.e. ankle joints, prosthetic liner, prosthetic feet and knees). We will honor all warranties under applicable law.

Failure to contact the treating practitioner or infrequent or non-use of a device does not absolve the patient from the responsibility for payment. Some of the devices are custom fabricated and prescribed by a physician and cannot be returned for credit on the account. **Prescribed off the shelf items cannot be returned for hygienic reasons**. However, patients may refuse delivery of any item if they feel it is not what was ordered, or what they expected after their initial assessment with the practitioner. It is the practitioner's responsibility to assess your abilities/disabilities and let you know what the ordered device will provide, its disadvantages, and what its limitations are.

It is in your best interest to communicate with your practitioner on a timely basis, keep your follow up appointments, and allow us to resolve any problems you are experiencing as efficiently and quickly as possible. It is our goal to provide you with the best care possible, and we will make every attempt to meet your needs. Please contact us if there is a question or concern that your practitioner cannot resolve for you.

FINANCIAL POLICY

As a courtesy to our patients we will bill your primary insurance. It is the responsibility of the patient to supply Thompsons Custom Orthotics and Prosthetics with the correct insurance/billing information. Incorrect information can result in patient responsibility for services; this may include the device, sales tax non-covered, non-billable and or items not authorized by your insurance provider. Payment in full is required at time of delivery unless prior arrangements have been made in advance.

Patient/Authorized Representative Signature**:**_____

Date:_____