Prosthetic & Orthotic Services

919 West Main Street | Walla Walla, WA 99362
Phone (509) 525-8322 | Fax (509) 525-2982

PATIENT INFORMATION *PLEASE PRINT CLEARLY*			
Full Name: First MI Last			
Address	City	State	Zip
Phone Number	Ok to leave a message? Yes No	Soc. Sec. No.(required)	
List other persons we can discuss appointment times with:			
Birthdate:	Sex (*circle one*) Male☐ Female☐	Marital Status (circle one) S M D W Other	
Current Prescriptions (required):			
Referring Doctor	Patient Employer		
Employer Address	Phone		
Is this visit a result of a work injury? Y N	Date Injured:	Industrial Claim No.:	
Is this visit a result of a car accident? Y N	Date of Accident:	Attorney Name:	
Allergies (list):			
INSURANCE INFORMATION *PLEASE PRESENT INSURANCE CARDS TO RECEPTION*			
Primary Insurance Company:	**Phone Number:**		
Insured's Name:	ID No.:	Group No.:	Birthdate:
Secondary Insurance Company:	**Phone Number:**		
Insured's Name:	ID No.:	Group No.:	Birthdate:

I certify that the information provided by me is true, accurate and complete.

x **x**

Signature of Patient **Date**

If representative, indicate relationship: _____

Acknowledgement of Receipt of Privacy Notice

I, the undersigned, certify that I (or my dependent) have insurance coverage as stated and assign directly to **Prosthetic & Orthotic Services** all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize the provider to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions. I fully understand I am responsible for payment of all charges. I have been presented with a copy of Columbia Basin Prosthetics & Orthotics, Inc. (dba Prosthetic & Orthotic Services) **Notice of Privacy Policies**, detailing how my information may be used and disclosed as permitted under federal and state law.
I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.
I understand the contents of the Notice, and **I request the following restriction(s)** concerning the use of my personal medical information (*if no restrictions, leave blank)*:

RECEIPT OF MEDICARE SUPPLIER STANDARDS DOCUMENTATION

I have received a copy of the **CMS MEDICARE DMEPOS SUPPLIER STANDARDS** that every durable medical equipment, and prosthetic/orthotic supplier must meet to obtain and retain their billing privileges.

Please sign and date at end of form…

Per HIPAA guidelines, please check if any apply to you:
☐ Do not phone at home
☐ Send all mail to an alternate address
☐ Do not leave messages on answering machine
☐ Do not leave message with individual other than patient
☐ Other privacy request _____

I have read and understand Privacy Practices; Medicare Supplier Standards and Privacy Restrictions

x **x**

Signature of Patient **Date**

If representative, indicate relationship: _____