AOPI ORTHOTICS & PROSTHETICS

Patient Registration

Patient's
Name:_____Birthdate:_____

Home: Address:_____ S.S. # _____

Mailing Address: _____

City:_____State:_____Zip:_____ □ Male □ Female

□ Single □ Married □ Divorced □ Widowed □ Employed □ Retired □ Student □ Disabled

Phone #_____ Cell # _____ EMAIL:_____

How did you hear about our facility:_____

EMERGENCY CONTACT Name:_____ Phone #_____ Relationship:_____

Insurance Information:
PRIMARY: _____ SECONDARY: _____
(If you are not the subscriber on all policies please complete below)

Subscriber:
Name: _____ Employer: _____
DOB: _____ SS#: _____ Relationship: _____

ARE YOU VA CONNECTED? YES NO

ARE YOU DIABETIC? YES NO

REFERING Physician (Who wrote the prescription?)

Physician/Clinic: _____Phone: _____

PRIMARY Physician (Required)

Physician/Clinic: _____Phone: _____

Authorization:

Please be aware that we collect estimated insurance portions at each visit. Your insurance policy is a contract between you and your insurance company. **You are responsible for any unpaid balances, regardless of the original estimate of insurance benefit**. As a courtesy to you, we will file your claim(s) with your insurance company. Insurance payment(s) are normally received within 30 to 45 days. **Any unpaid balances after 60 days are your responsibility and are due at that time. All deductibles and copayments are due at the time of service.** A completed claim form or copy of your insurance card will need to be kept on file in our office. We try to answer any questions you may have about your insurance company, however you may need to contact your insurance company for additional information.

IT IS YOUR RESPONSIBILITY TO PROVIDE ALL INSURANCE INFORMATION TO OUR OFFICE. IF YOUR INSURANCE CHANGES, IT IS YOUR RESPONSIBILITY TO PROVIDE UPDATED INFORMATION TO OUR OFFICE. IF YOU DO NOT PROVIDE THE CORRECT INFORMATION YOU WILL BE RESPONSIBLE FOR ANY CHARGES AS A RESULT.

- I authorize AOPI to carry out the instructions on my prescription from my physician. **I further authorize the release of any information regarding my condition/treatment, as necessary, to process related claims. I hereby request my medical records be released to AOPI Orthotics and Prosthetics. (fax)706-733-4434 (phone) 706-733-8878**
- I understand that I am responsible for all fees not covered by Insurance, Medicare, Medical Assistance or other Governmental Agencies, or Worker's Compensation. I also authorize for payment to be made directly to AOPI.
- Waiver for new Medicare beneficiary's only. Medicare only pays for one pair of diabetic shoes and 6 inserts per year. If you receive another pair of shoes within this year without informing AOPI, you will be responsible for the full amount of shoes and inserts.

Signature_____Date_____
(Signature of patient, guardian, or personal representative.)