

PATIENT INFORMATION

Thank you for selecting Powell Orthotics & Prosthetics. In order to serve you properly, PLEASE PRINT all of the following information. All information will be kept confidential, according to HIPPA regulations.

Patient Name _____ Gender: M or F Today's Date: _____
 Address _____ City _____ State _____ Zip _____
 Home Phone () _____ - _____ Work Phone () _____ - _____ Cell () _____ - _____
 Email Address _____
 Patient's Social Security # _____ Patient's Date of Birth _____
 Relationship to Patient _____ Parent, guardian, or spouse's name _____
 Which body part /area are we treating, please be specific _____
 Reason for Treatment (Diagnosis) _____
 Date of Injury or amputation if applicable _____

PHYSICIAN INFORMATION

Referring Physician _____ Phone () _____ - _____
 Primary Care Physician _____ Phone () _____ - _____

Medicare Assign of Benefits

I request that payment of authorized Medicare benefits be made on my behalf for any services furnished me by T.G. POWELL Inc. I authorize any holder of medical information or other information about me to release to the health care financing administration and its agents any information needed to determine these benefits.

Signature of Patient, Guardian or parent if patient is a minor

Date

Pages 1 of 2 pages please fill both forms out completely

INSURANCE INFORMATION

As a courtesy, we call your insurance company to check the benefits for the orthotic/prosthetic equipment prescribed for you. Any benefit information quoted to you is based on the information obtained from the insurance company and is not a guarantee of you benefits or payment. We will assist in obtaining an authorization for the equipment when required and will not release any merchandise until authorization and all co-insurance and deductibles are paid in full.

Is this a worker's compensation claim? No YES: If Yes, please request the appropriate form.

INSURANCE COMPANY _____ Identification Number _____

Name of *Policy Holder* _____ Relationship to Patient _____

Date of Birth of *Policy Holder* _____ Employer _____

If different from above: Address _____ City _____ State _____ Zip _____

Home Phone () _____ - _____ Work Phone () _____ - _____ Cell () _____ - _____

SECONDARY INSURANCE _____ Identification Number _____

Name *Policy Holder* _____ Relationship to Patient _____ Date of Birth of *Policy Holder* _____

Address (if *different*) _____ City _____ State _____ Zip _____ Phone () _____ - _____

I authorize the release of health information concerning me or my child's health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize my insurance company to pay directly to Thomas G. Powell, Inc. / Powell Orthotics & Prosthetics, insurance benefits otherwise payable to me. I understand my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on me or my dependents behalf. Please contact us if an item you have received does not fit properly. No returns will be accepted after three (3) business days. I agree to pay all costs incurred in the collection process, including court costs and attorney fees.

Signature of Patient, Guardian or parent if patient is a minor

Date

PAYMENT POLICY

I understand that I will be fully responsible for any balance due and owing on this or any account that I might have with **THOMAS G. POWELL, INC.** Should an account become delinquent beyond 30 days, I understand that it may be turned over to an attorney for collection. In this event, I understand that I will be responsible for all court cost & attorney fees up to 33-1/3 %. I also agree to pay 1-1/2% (18% Per Annum) interest on any balance over 30 days.

I further understand that in the event an account is delinquent, **THOMAS G. POWELL, INC.** may suspend any and all work and/ or repair to devices which I have purchased from them until such time as my account is brought current and I waive my rights to hold **THOMAS G. POWELL, INC.** liable for any negligence or damages resulting from their suspension of work due to my delinquent account..

My signature assigns benefit to **THOMAS G. POWELL, INC.** for services rendered. I agree to notify T.G. Powell, Inc. immediately of any change in insurance coverage or status.

Signature of Patient, Guardian or parent if patient is a minor

Date