Adaptive Prosthetics: Patient Information

52 National Dr, Glastonbury, CT

100 Retreat Ave, Hartford, CT / 567 Vauxhall St Ext, Waterford, CT / 113 Salem Tpk, Norwich, CT / 35 Wells St, Westerly, RI

PATIENT INFORMATION	PATIENT NAME: ______________________ DATE OF BIRTH: ______________ ADDRESS: ______________________ SOC SECURITY #______________ CITY, STATE, ZIPCODE: ______________________ PHONE: ______________ CELL PHONE: ______________ EMAIL: ______________________
	How did you hear about us? ______________________
DOCTOR	REFERRING PHYSICIAN:______________________ PHONE:______________ ADDRESS: ______________________
INSURANCE	PRIMARY: ______________________ Company Policy # Insured Name SECONDARY: ______________________ Company Policy # Insured Name

HIPAA	• Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, and the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you to read it carefully and completely before signing this Consent. • Purpose of Consent: By signing this form, you consent for Adaptive Prosthetics to use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.
COMMUNICATION AUTHORIZATION	I authorize Adaptive Prosthetics to leave messages on my home phone/cell phone or contact me by e-mail.
MEDICARE SUPPLIER STANDARDS	"The products and/our services provided to you by Adaptive 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."
ASSIGNMENT OF BENEFITS	I authorize my insurance company to pay benefits directly to Adaptive Prosthetics. I understand my insurance company may not pay for services that are not a covered benefit or are not considered medically necessary. I also understand that there may be benefit limitations with no-fault carriers as deductibles and benefit maximums may apply. I agree to be financially responsible for all services provided by Adaptive Prosthetics.
SIGNATURE	**I HAVE READ, UNDERSTOOD, AND HEREBY AGREE TO ALL OF THE STATEMENTS NOTED ABOVE.** ______________________ ______________ PATIENT OR AUTHORIZED REPRESENTATIVE SIGNATURE: DATE: If Representative Print Name: Relationship: