

Faith Regional Prosthetic-Orthotic Services Registration Form

Today's Date: _____

Patient Account #: _____

PATIENT INFORMATION

Last Name:	First Name:	Mid Init:	<input type="checkbox"/> Mr. <input type="checkbox"/> Miss <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid
Social Security:	Date of Birth:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Driver's License Number:
Street Address:		City:	State:	Zip:
Does patient reside in a nursing home or assisted living? Yes or No				
If yes, please give name of facility: _____				
Home Phone:	Cell Phone:	Work Phone:	Email Address:	Employer Name:
Person responsible for bill (if different than above):				
Name:		DOB:	Address:	Phone:

IN CASE OF EMERGENCY

Emergency Contact:	Relationship:	Home Phone:	Work/Cell Phone:
Emergency Contact (Not Living With You):	Relationship:	Home Phone:	Work/Cell Phone:

MEDICAL INFORMATION

Are you a diabetic? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, how is it controlled: <input type="checkbox"/> Insulin <input type="checkbox"/> Pill <input type="checkbox"/> Diet)	Height:	Weight:	Diagnosis:
Referring/Treating Physician Name:	Physician Phone #:	Date last seen by Physician:	Are Services Work Related? <input type="checkbox"/> No <input type="checkbox"/> Yes

INSURANCE INFORMATION

Please give the receptionist a copy of your insurance card(s)

Primary Insurance	Primary Insurance Company:	Policy #:	Group #:	Patient's Relationship to Insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
	Subscriber Name:		Subscriber SS#:	Subscriber Birth Date:
	Subscriber Employer:		Employer Address:	Employer Phone:
Secondary Insurance	Secondary Insurance:	Policy #:	Group #:	Patient's Relationship to Insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
	Subscriber Name:		Subscriber SS#:	Subscriber Birth Date:
	Subscriber Employer:		Employer Address:	Employer Phone:

Attention Medicare Patients: Medicare Authorization

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Faith Prosthetic-Orthotic Services Regional Centers for any services furnished to me by the provider. I authorize any holder of medical information about me to be released to the Healthcare Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made on the claim. If "other health insurance" is indicated in item 9 on the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of information to the insurer or agency shown, in Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier. I also, acknowledge that I have received a copy of the Medicare Supplier Standards.

Patient/Guardian Signature _____ Date _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Faith Prosthetic-Orthotic Services Regional Center. I understand that I am financially responsible for any balance. I also authorize Faith Prosthetic-Orthotic Services or insurance company to release any information required to process my claims. I acknowledge that I have received a copy of the HIPAA privacy standards and the company warranty information.

Patient/Guardian Signature _____ Date _____

Intake By (initials): _____

Faith Prosthetic-Orthotic Regional Services
HEALTH QUESTIONNAIRE

Today's Date:

Last Name:	First Name:	Mid Init:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth:
Height:	Weight:	Referring Physician Name:		Date of Last Physical:

TODAY'S VISIT

Reason for today's visit:

Explain how your current injury/illness/amputation occurred: _____ Date of injury/illness/amputation: _____

List your current treating physician and any other physician, physical therapist, or rehabilitation/skilled nursing/assisted living facility for the past year.

What are your expected goals or activities you wish to resume?

CURRENT HEALTH AND WELL-BEING

<p>Which best describes your exercise/activity level?</p> <p><input type="checkbox"/> Sedentary (No Exercise)</p> <p><input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)</p> <p><input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4 times/ week for 30 min.)</p> <p><input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation, 4 times/ week for 30 min.)</p>	<p>Mental Health Overview:</p> <p>Is stress a major problem for you? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you feel depressed? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you panic when stressed? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you have problems with eating or your appetite? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Do you live alone? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Do you have vision or hearing loss? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Do you have frequent falls? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

ALLERGIES TO MEDICATIONS, LATEX, OR CREAMS

Name of drug or product:	Type of reaction:

HEALTH HISTORY

Did you have any of the following childhood illnesses?
 Measles Mumps Rubella Chickenpox Rheumatic Fever Polio

Check if you have, or have had, any symptoms in the following areas to a significant degree and explain briefly below:
 Skin Head/Neck Lungs Chest/Heart Back Circulation

Have you had any recent significant changes in weight or energy level? No Yes (If yes, please explain below)

List any other medical problems that you currently have or have had in the past:

Surgeries			Hospitalizations		
Year	Procedure	Hospital	Year	Procedure	Hospital

FAMILY HISTORY

Please list any significant health problems that are affecting, or have affected, a family member. Please also specify their relationship and age.

By signing below, I certify that the information above is true to the best of my knowledge.

Signature: _____ Date: _____

Intake By (initials): _____

Authorization by Individual for Faith P & O to Use or Disclose PHI to Another Person

I authorize **Faith Prosthetic-Orthotic Services** to use or disclose my protected health information (PHI), as follows:

To: _____
Identify or name person(s) or class of persons to whom Faith may make the requested use or disclosure.

What: _____
Specific description of the Individual's protected health information to be used or disclosed

For: _____
Description of each purpose of the requested use or disclosure

By signing this form, I consent to the use or disclosure of my protected health information by **Faith Prosthetic-Orthotic Services** for the purpose of providing treatment to me, obtaining payment for my healthcare bills or to conduct the Company's healthcare options. I understand I have the right to revoke this consent, **in writing**, at any time except to the extent that **Faith Prosthetic-Orthotic Services** has taken action in reliance to my prior consent.

My "protected health information" means any of my written and oral health information, including my demographic data that can be used to identify me, that has been created or received by **Faith Prosthetic-Orthotic Services**, and that relates to my past, present or future physical or mental health condition.

I understand I have the right to review **Faith Prosthetic-Orthotic Services** Notice of Privacy Practices prior to signing this document. 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 my bills, or in the performance of our healthcare operations. The Notice of Privacy Practices also describes my rights and the company's rights and the Company's duties with respect to my protected health information. The Notice of Privacy Practices is posted in the clinic lobby.

As noted in **Faith Prosthetic-Orthotic Services Notice**, the Company reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I understand that I may obtain a revised Notice of 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.

I understand I have the right to request restrictions as to how my protected health information is used or disclosed to carry out treatment, payment for our healthcare operations. **Faith Prosthetic-Orthotic Services** is not required to agree to the restrictions that I may request, but if it does, it is bound by this agreement.

I understand that diagnosis or treatment of me by **Faith Prosthetic-Orthotic Services** may be conditioned upon my consent as evidenced by my signature on this document.

Signature of Patient or Personal Representative

Date

Printed Name of Patient or Personal Representative

Intake By (initials): _____

FAITH PROSTHETIC-ORTHOTIC SERVICES, INC.
1025 Concord Parkway, N
Concord, NC 28027
Phone: 704-782-0908

CONFIDENTIAL REQUEST FOR RELEASE OF MEDICAL RECORDS

I understand that the following release is to be used between Faith Prosthetic-Orthotic Services, Inc. and my prescribing physician, to obtain records if necessary in order to provide information to Faith or to my insurance company.

Physician's Name:		
Facility Name:		
Address 1:		
Address 2:		
City:	State:	Zip:
Phone:	Fax:	

I hereby request that my medical records be released to:

FAITH PROSTHETIC-ORTHOTIC SERVICES

Center: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Patient's Name:	Date of Birth:
Signature:	Date:

Intake By (initials): _____