ARTHUR FINNIESTON
PROSTHETICS + ORTHOTICS

Patient Information Form

Patient's Name: _____

Address: _____City: _____ST: ___Zip: _____

Telephone: Home:_____Work: _____Cellular: _____

Email: _____

_____

S.S #_____ Height: _____Weight: _____Date/Birth: _____ Age: __

Male ____Female ____ Amputation BK____AK____AE___BE___HD___ KD___ Side Affected R__L__

Marital Status: Single___Married____Other___

Diagnosis: _____Cause: _____

Date of Surgery:_____Surgeon:_____

Referring Physician:_____Phone:_____

Parent/Guardian:_____Phone: _____

Address if different from Patient:_____

Source of Payment: Check/Cash/Credit Card _____Workman's Comp:_____ Other: _

Workman's comp or auto insurance: _____

Employer:_____Phone:_____

Adjustor: _____Phone: _____Claim # _____

Was injury work related? Yes No If yes, give date: _____

Was it a vehicle accident? Yes No If yes, give date: _____

Primary Insurance Co: _____ Plan ID # _____

Name of Insured person: _____Group #_____

Secondary Insurance Co: _____ID#_____Group # _____

How did you hear of us? _____

The Patient/Guardian is responsible for all clinic fees regardless of the insurance coverage. I authorize the release of any medical information including video/photo necessary to produce a claim. Also, I authorize any video/photo(s) necessary for educational presentations.

Patient/Parent/Guardian Signature:_____ Date: _____

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Acknowledgement of Receipt of Notice of Privacy Practices

And Consent for Use and Disclosure of Protected Health Information

Use and Disclosure of Your Protected Health Information
Your protected health information will be used by Arthur Finnieston, Inc. or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices
You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use of Disclosure of Your Information
You may request a restriction on the use or disclosure of your protected health information. Arthur Finnieston, Inc. may or may not agree to restrict the use or disclosure of your protected health information. If Arthur Finnieston, Inc. agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent
You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected. You will not be penalized or otherwise retaliated against for filing a complaint.

Reservation of Right to Change Privacy Practices
Arthur Finnieston, Inc. reserves the right to modify the privacy practices outlined in the notice.

Signature
I have reviewed this consent form and give my permission to Arthur Finnieston, Inc. to use and disclose my health information in accordance with it.

_____
Name of Patient (Print or Type)

_____
Signature of Patient Date

_____
Signature of Patient Representative

_____
Relationship of Patient Representative to Patient

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Insurance Release and Assignment

Patient Name: _____ Account Number: _____

Assignment of Insurance Benefits

I authorize and request your company to pay directly to the **Arthur Finnieston Inc.** in the amount due in my pending claim for medical, orthotic or prosthetic treatment.

Release of Information

I hereby authorize **Arthur Finnieston Inc** to release to your company or its representative any information, including the diagnosis and the records of any treatment or service rendered to my dependent, or me, during the period of such medical care.

A photostatic copy of this authorization shall be considered as effective and valid as the original.

Signature **Date** **Insurance Carrier**