NEW PATIENT FORM

Instructions: Please fill out only the items shown in black. Do not fill out the items shown in gray.

SNELL Prosthetics & Orthotics

ID _____

PATIENT INFORMATION

Name _____

Address _____

City _____

State _____ Zip _____

Phone (_____) _____

Work (_____) _____

Date of Birth _____

Referral Source _____

Referring Physician _____

Primary Physician _____

Specialist _____

Location _____

Patient E-mail _____

Sex ____ M ____ F

Social Security # _____

Account Type _____

Account Status _____

Tax Type _____

Diagnosis _____

Is this work related? ___ Yes ___ No

Date of Injury _____

Notes:

EMERGENCY INFORMATION

Name _____

Address _____

City _____

State _____ Zip _____

Phone (_____) _____

Work (_____) _____

EMPLOYER INFORMATION

Name _____

Address _____

City _____

State _____ Zip _____

Phone (_____) _____

Work (_____) _____

Contact _____

Is your treatment today due to a recent surgery? ___ Yes ___ No

Is your treatment today due to a recent injury? ___ Yes ___ No

Are you living or staying in a skilled nursing facility? ___ Yes ___ No

Are you living or staying in a rehab facility? ___ Yes ___ No

Would you like to talk with a practitioner prior to having your prescription filled? ___ Yes ___ No

I hereby request and authorize my insurance company and/or companies to pay directly to Snell Prosthetics & Orthotics any proceeds payable under the terms of my policy and/or policies. This is an irrevocable assignment and I understand and agree any unpaid balance not covered by this policy is my obligation and will be paid by me. I also give my consent to Snell Prosthetics & Orthotics to release and obtain information pertaining to my condition for treatment, payment, and operations effective on the date below. I understand that I have the right to revoke this consent in writing to the Privacy Officer.
***Medicare Beneficiary: I have been notified and I am aware of Medicare Supplier Standards.**

Date _____ Signed _____

Form must be scanned into OPIE HIPAA Tab

Snell Prosthetics & Orthotics
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of evaluations will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Healthcare operations. Your health information may be used as necessary to support the day-to-day activities and management of Snell Prosthetics & Orthotics. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department. Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information on the treatment and management of your medical condition or new technology that you may find to be of interest. We may also send you information describing other health-related goods and services that we believe may interest you.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices for Snell Prosthetics & Orthotics.

_____ _____

Signature of Patient or Authorized Representative Date

If representative, print name and relationship:

_____

DON'T FORGET TO BRING THE FOLLOWING...

When you come to Snell Prosthetics & Orthotics for the first time, please bring the following items:

- ☑ Your Physicians Prescription
- ☑ Your New Patient Form (Please complete this form and bring it with you.)
- ☑ Your Insurance, Medicare or Medicaid Information
- ☑ A Family Member or Friend (Bringing another person can be helpful to you. They can help you remember instructions and may ask questions that you did not think to ask.)
- ☑ Please arrive fifteen minutes prior to your scheduled appointment time if this is your first appointment.