WESTCOAST

Restoring bodies. Rebuilding lives.

NEW PATIENT FORMS

PATIENT INFORMATION

Date _____

Is your visit with us related to a work comp injury? ☐ YES ☐ NO *(If YES, complete last page)*

Patient Name: First: _____ Middle Initial: _____ Last: _____

Social Security #: _____ - _____ - _____ DOB: _____- _____ - _____ ☐ Male ☐ Female

☐ Single ☐ Married ☐ Other

Phone: _____ Work: _____ Cell: _____

☐ *By checking this box, you authorize Westcoast Brace & Limb to leave detailed phone messages for you, which may include private healthcare information.*

Email: _____

Address: _____ City: _____ State: _____ Zip: _____

☐ *By checking this box, you authorize Westcoast Brace & Limb to utilize email as a form of communication with you. Our communications only include information regarding your treatment plan, updates, and our services. Your social security number will never be included in an email communicate from us.*

RESPONSIBLE PARTY

(Check one): ☐ The responsible party listed above ☐ Is different than above

Full Name: _____ Relationship: ☐ Self ☐ Spouse ☐ Dependent ☐ Other

Social Security #: _____ - _____ - _____ DOB: _____- _____ - _____

Phone: _____ Work: _____ Cell: _____

EMERGENCY CONTACT

Full Name _____ Phone _____

MEDICAL PROFESSIONALS INVOLVED IN YOUR CARE

☐ Prescribing Physician: _____ Phone: _____

☐ Primary Care Physician: _____ Phone: _____

☐ Other_____ Phone: _____

OTHER HEALTH CONDITIONS (Please check all that apply):

☐ Arthritis
☐ Osteoporosis
☐ Fibromyalgia
☐ Joint Pain
☐ Muscle Pain
☐ Vascular Disease
☐ Previous Heart Attack
☐ Gout
☐ Stroke
☐ Chronic Pain
☐ Chronic Fatigue Syndrome
☐ Autoimmune Disease
☐ Rheumatoid Arthritis
☐ Obesity
☐ Type 1 Diabetes
☐ Type 2 Diabetes
☐ Wound Heal Delay
☐ Respiratory Disease
☐ Depression
☐ Anxiety
☐ Memory Loss
☐ Cancer
☐ Parkinson's Disease
☐ Multiple Sclerosis
☐ Seizures
☐ Cerebral Palsy
☐ Post-Polio
☐ HIV/AIDS
☐ MRSA
☐ Pregnancy
☐ Previous Surgery:

_____

WESTCOAST

Restoring bodies. Rebuilding lives.

NEW PATIENT FORMS

INSURANCE INFORMATION

Please provide a copy of your photo ID, all insurance cards, and any prescriptions that you have.

Primary Insurance: _____ Policy ID: _____ Group: _____

If the policy holder is someone other than the patient: ☐ Spouse ☐ Dependent ☐ Not related

Policy Holder Name: _____

DOB: _____ - _____ - _____ Social Security: _____ - _____ - _____

Secondary Insurance: _____ Policy ID: _____ Group: _____

If the policy holder is someone other than the patient: ☐ Spouse ☐ Dependent ☐ Not related

Policy Holder Name: _____

DOB: _____ - _____ - _____ Social Security: _____ - _____ - _____

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I, _____ give permission to Westcoast Brace & Limb to release any information, verbally or written, on my behalf to the following persons. Please note that in order for WCBL to communicate to anyone other than the patient/guardian, that individual's name must be listed below.

Name:_____ Phone: _____

Relationship to Patient _____

CLINICAL PHOTOGRAPH RELEASE

I understand that Westcoast Brace & Limb may obtain a photograph of me for clinical purposes. This photograph of me will remain in my records and may be forwarded to my treating medical professional(s) (physician, nurse, therapist, etc...) for clinical purposes.

Patient/Guardian Signature: _____ Date: _____

How did you hear about Westcoast Brace & Limb? (Check all that apply)

☐ Medical Professional ☐ Hospital Visit ☐ Insurance ☐ Internet ☐ Print Ad

☐ Television ☐ Another WCBL Patient ☐ Military Base/MAFB ☐ WCBL Mailer/Postcard

PATIENT CONSENT & AUTHORIZATION FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I acknowledge receipt of notice of privacy practices and authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment of other healthcare providers/vendors involved in my treatment)
- Obtaining payment from third party payers
- The normal healthcare operations of your practice

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that I may contact you to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree with these restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use of disclosure that occurred prior to the day I revoked this consent is not affected.

In the event this practice changes hands, I also give you permission to transfer my records.

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but could not obtain because:

☐ Individual refused to sign

☐ Communication barrier prohibited

☐ An emergency situation prevented obtaining acknowledgement

☐ Other _____

WESTCOAST

Restoring bodies. Rebuilding lives.

NEW PATIENT FORMS

BENEFITS, MEDICAL INFORMATION RELEASE AUTHORIZATION & ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

I request my insurance benefits, if any, be paid directly to the provider. I authorize the release of any information necessary to provide services or process claims. As the responsible party, I understand that I am personally responsible for the entire amount of my claim and that insurance benefits may be limited or non-existent. I agree to notify Westcoast Brace & Limb of any change in insurance coverage of status.

LIFETIME MEDICARE B SIGNATURE & ASSIGNMENT OF/AND AUTHORIZATION TO PAY MEDICAL EXPENSE BENEFITS

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration, to its' intermediaries or carriers or billing agent of designated carrier, any information needed to this or a related claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the party who accepts assignment.

If policy specifically prohibits assignment, I request a check be made payable to BOTH SUBSCRIBER AND ABOVE COMPANY and sent directly to the COMPANY. NOTE: Payment by an obligor to a person other than the assignee after notification of assignment may result in liability to the obligor to repay the amount paid.

SECONDARY INSURANCE AUTHORIZATION & ASSIGNMENT

I authorize payment of medical benefits to the party who accepts assignment.

RESPONSIBILITY

I understand that the entire amount of the fees for your services and/or Orthotic and Prosthetic devices is my personal responsibility even though this may or may not be covered by insurance. If you bill the insurance company directly, I understand that I am to pay my portion of the bill when your service is rendered. I further agree to personally pay within thirty (30) days any portion of the bill that is outstanding.

In the event this bill is turned over to a third party for collection, I agree to pay all reasonable collection fees including attorney and Court cost, plus 1.5 percent monthly charge on the outstanding balance.

Patient Signature: _____

Date: _____

WESTCOAST

Restoring bodies. Rebuilding lives.

NEW PATIENT FORMS