Patient Information Sheet

Select Office Location:

☐ Arcadia ☐ Downey ☐ Long Beach ☐ Orange Co.

PATIENT INFORMATION

______________________________ ______________ ____________________
FIRST NAME MIDDLE INITIAL LAST NAME DATE OF BIRTH SOCIAL SECURITY NUMBER

____
ADDRESS APT# CITY STATE ZIP

(________)______________________ (________)____________________ ______________________
HOME PHONE NUMBER CELL PHONE NUMBER BEST TIME TO REACH YOU

______________________________ ____________ ________ ________
E-MAIL ADDRESS MALE / FEMALE MARITAL STATUS HEIGHT WEIGHT

______________________________ ________________ ______________
DRIVER'S LICENSE # STATE EXP DATE OCCUPATION

______________________________________ (_________)________________________
EMPLOYER EMPLOYER PHONE

______________________________________ (_________)________________________
EMERGENCY CONTACT PHONE NUMBER

INSURANCE INFORMATION Medicare Medi-Cal CCS HMO PPO Private VA Cash Other

______________________________________ (_________)________________________
NAME OF PRIMARY PHYSICIAN PHYSICIAN PHONE NUMBER

______________________________________ (_________)________________________
NAME OF REFERRING PHYSICIAN (IF DIFFERENT) PHYSICIAN PHONE NUMBER

*****THE FOLLOWING INSURANCE INFORMATION MUST BE FOR THE INSURED PARTY:**

____________________ ____________________ ______________________
PRIMARY INSURANCE MEMBER ID# MEMBER SS# AND DATE OF BIRTH

____________________ ____________________ ______________________
SECONDARY INSURANCE MEMBER ID# MEMBER SS# AND DATE OF BIRTH

DOES THE PATIENT HAVE A CCS CASE? YES NO IF YES, WHAT IS THE CASE NUMBER?______________

WERE YOU INJURED AT WORK? YES NO

______________________________________ ________________________________
NAME OF EMPLOYER AT TIME OF INJURY DATE OF INJURY

______________________________________ ________________________________
NAME OF WORKER'S COMPENSATION CARRIER CLAIM NUMBER

PLEASE READ THE FOLLOWING AND SIGN BELOW

I hereby authorize Orthotic/Prosthetic services prescribed by my physician. I hereby authorize Human Designs to furnish my insurance company with all information they request. I also instruct my insurance company to issue payment of my claim directly to Human Designs. I understand that if my insurance company requires authorization and I choose to receive services before the written authorization has been received by Human Designs, I will accept financial responsibility for all charges. **I understand that even if services are authorized, but I am not eligible on the date of service, or if it is later determined that my policy does not cover the item(s) I am receiving, I WILL BE RESPONSIBLE FOR PAYMENT IN FULL.** I further understand that my insurance company may deduct a CO-INS, SHARE OF COST or DEDUCTIBLE from their payment to Human Designs, and I agree to pay PROMPTLY for these amounts. I understand that items received may not be returned or payments refunded in order to reduce my financial responsibility. My signature also represents my permission for my doctor, medical group, and/or hospital to release any medical records necessary for the processing of my claim(s).

____
PATIENT OR PERSONAL REPRESENTATIVE DATE

Office Use Only:

THIS INFORMATION IS REQUIRED TO DETERMINE COVERAGE OF SERVICE TO BE PROVIDED

Has the patient ever received the same or similar device? Yes No

If yes, list the device provided:______________________________

Did Human Designs provide the device?______________________________

Estimated Date Provided:______________________________

Was device returned to original supplier? Yes No

Is the device being replaced? Yes No

Is there new medical necessity? Yes No

Describe condition for previous need______________________________

Describe new/changed condition______________________________

ACKNOLWEGDEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I certify that I have received a copy of the Human Designs' Notice of Privacy Practices (Notice). The Notice 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 Human Designs' health care operations. The Notice also describes my rights and Human Designs' duties with respect to my protected health information. The Notice is posted in patient treatment rooms and on Human Designs' website at www.humandesigns.com.

Human Designs reserves the right to change the privacy practices that are described in the Notice. I may obtain a revised Notice by calling the office and requesting a revised copy to be sent in the mail, asking for one at the time of my appointment, or accessing Human Designs' website.

I have received the Medicare Supplier Standards ☐ Yes ☐ No

______________________________ ______________________________
SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE DATE

______________________________ ______________________________
PRINT NAME OF PATIENT OR PERSONAL REPRESENTATIVE DATE

INSURANCE INFORMATION

We will verify your insurance for the device prescribed by your physician and advise you of the benefit information we receive from your insurance company. We are not responsible for incorrect benefit information provided to us by your insurance during the verification process. Please refer to your benefits book and/or consult your insurance carrier for further details and assistance.

______________________________ ______________________________
SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE DATE

Human Designs Prosthetics and Orthotics
Main Office
2933 Long Beach Boulevard
Long Beach CA 90806

CONFIDENTIAL REQUEST FOR MEDICAL RECORDS

I understand that the following release is to be used between Human Designs Prosthetics and Orthotics, and my prescribing physician to obtain records, if necessary in order to provide information to Human Designs or to my insurance company.

To: ______________________________
(Referring Physician's Name)

Address: ______________________________
____
____

I hereby request that my medical records be released to: Human Designs Prosthetics and Orthotics

(choose office location below)

☐ Long Beach
2933 Long Beach
Long Beach CA
Ph: 562 988-2414
Fx: 562 490-2831

☐ Arcadia
49 E Foothill Blvd
Arcadia CA 91006
Ph: 626 445-7797
Fx: 626 445-7873

☐ Tustin
1541 Parkway Loop
Tustin CA 92780
Ph: 714 258-8144
Fx: 714 258-8140

☐ Downey
8734 Cleta St. Unit C
Downey CA 90241
Ph: 562 988-2414
Fx: 562 490-2831

Patient's Printed Name: ______________________________

Patient's Signature: ______________________________ **Date:** ____________

*This request is valid for one year from the patient signature date. Expiration Date: ________