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

LOWER LIMB PROSTHETIC ASSESSMENT FORM

PATIENT INFORMATION

Name: ______________________ Evaluation Date: ______________

D.O.B. ______________________ Practitioner: ______________

Height: ______________________ Location of Patient Evaluation:

Weight: ______________________ ☐ Office ☐ Rehab Hospital ☐ Home

Sex: ☐ Male ☐ Female ☐ Skilled Nursing Facility ☐ Other

INITIAL OBSERVATION AND DIAGNOSIS

Amputation Date: ______________ Referring Physician: ______________

Amputation Side: ☐ Right ☐ Left ☐ Bilateral Date of Last Appointment: ______________

ICD-9 Amputation Level

895.00 ☐ Toe	897.2 ☐ Trans-Femoral
896.00 ☐ Partial Foot	897.4 ☐ Hip Disarticulation
896.00 ☐ Ankle Disarticulation	897.4 ☐ Pelvic Disarticulation
897.00 ☐ Trans-Tibial	897.4 ☐ Not otherwise specified
897.20 ☐ Knee Disarticulation	897.6 ☐ Bilateral

Cause of Amputation

☐ Diabetes	☐ Motor Vehicle Accident	☐ Congenital
☐ Cardiovascular disease	☐ Peripheral vascular disease	☐ Other______________
☐ Trauma		

TYPE OF SERVICE

New Patient/Service:	☐ Yes ☐ No		
Replacement:	☐ Entire ☐ Socket ☐ Components______________________________		
Replacement Due To:	☐ Change in Residual Limb	☐ Functional Activity Level	☐ Wear & Tear
	☐ Weight Gain ☐ Loss	☐ Irreparable Damage	☐ Other:_____
Type of Prosthesis :	☐ IPOP	☐ Definitive	☐ Cosmetic
	☐ Prepatory	☐ Sport	☐ Endoskeletal
	☐ Exoskeletal	☐ Other:	
Details:			

MD Signature________________

DAILY LIVING INFORMATION

Living Status:	☐ Alone in Home ☐ Home with Spouse/Family ☐ Long Term Care Facility ☐ Other
Living Conditions:	☐ Level Surfaces ☐ Level with Steps ☐ Uneven Surfaces ☐ Uneven with Steps
Patient's Vocation:	Seated____% Standing____% Variable Cadence ___%
Recreation:	☐ Bicycling ☐ Walking ☐ Sports ☐ Swimming ☐ Running ☐ Aerobics ☐ Shopping ☐ Domestic Chores ☐ Other ______________
Physical Therapy:	☐ Does not go ☐ Ongoing ☐ Needed ☐ Pt would like a referral
Current Assistive Devices Used:	☐ Handrails Present (home) ☐ Walker ☐ Cane ☐ Ramps present (home) ☐ Crutch(s) ☐ Wheelchair
Transportation Used:	☐ Drives own car ☐ Rides in Car ☐ Buses ☐ Trains ☐ Other
Desire to Ambulate:	Describe patients pre-amputation status: Is the patient motivated to ambulate: ☐ Yes ☐ No Describe the patients level of motivation to ambulate:

PROSTHETIC HISTORY

☐ Patient has never worn a prosthesis
☐ Patient currently has a prosthesis

Number of years patient has worn a prosthesis:______year(s)

Age of current prosthesis:_________month(s) or ______years(s)

Daily wearing schedule: ______hours per day

Design and condition of current prosthesis: ☐ N/A

☐ Endoskeletal ☐ Exoskeletal

Socket: ______________________________ ☐ *Acceptable as is*
☐ *Needs to be replaced because:*

Knee: ______________________________ ☐ *Acceptable as is*
☐ *Needs to be replaced because:*

Suspension: ______________________________ ☐ *Acceptable as is*
☐ *Needs to be replaced because:*

Foot/Ankle: ______________________________ ☐ *Acceptable as is*
☐ *Needs to be replaced because:*

Describe condition of current prosthesis: ______________________________

Does present prosthesis meet patient's current needs? (Function, safety, etc.) ☐ N/A ☐ Yes ☐ No
If no, explain: ______________________________

RESIDUAL LIMB HEALTH

Length Overall:	________ ☐ inches ☐ cm		
Tissue Consistency:	☐ Soft	☐ Medium	☐ Firm
Skin Condition:	☐ Normal	☐ Discoloration	☐ Open Wounds
Limb Shape:	☐ Normal	☐ Bulbous	☐ Conical
Contracture:	☐ Flexion	☐ Abduction	☐ None present
Other:	☐ Scars	☐ Bony Prominence	☐ Neuroma

Residual Limb Measurements: _________________Circumference _________________ Distance from IT

MD Signature________________

FUNCTIONAL LEVEL ASSESSMENT

K0 ☐ Does not have the ability or potential to ambulate or transfer safely with or without assistance and a prosthesis does not enhance their quality of life or mobility.

K1 ☐ **Household Ambulator:** Has the ability or potential to use a prosthesis for transfers or ambulation on level surfaces at a fixed cadence.

K2 ☐ **Limited Community Ambulator:** Has the ability or potential for ambulation with the ability to traverse low level environmental barriers such as curbs, stairs, or uneven surfaces.

K3 ☐ **Unlimited Community Ambulator:** Has the ability or potential for ambulation with variable cadence. has the ability to traverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion.

K4 ☐ **Child, Active Adult or Athlete:** Has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress, or energy levels.

Patients Existing Environmental Barriers	☐ Level Surfaces ☐ Level with steps ☐ Uneven surfaces ☐ Uneven with steps ☐ Ramps or Slopes ☐ Other
Gait Observations:	

PROSTHETIC RECOMMENDATIONS

Type of Prosthesis Required:	☐ Partial Foot ☐ Symes ☐ Below Knee ☐ Above Knee ☐ IPOP ☐ Preparatory/Temporary ☐ Definitive ☐ Other:

Foot: ______________________

Rationale:
☐ Reduce Energy Consumption ☐ Increased Stability
☐ Walk on Uneven Terrain ☐ Variable Cadence

Comments: ______________________

Knee: ______________________

Rationale:
☐ Reduce Energy Consumption ☐ Increased Stability
☐ Variable Cadence ☐ Increased Comfort

Comments: ______________________

Suspension: ______________________

Rationale:
☐ Reduce Skin Abrasion ☐ Increased Stability
☐ Increased Prosthetic Control ☐ Increased Comfort

Comments: ______________________

Socket: ______________________

Rationale:
☐ Increase Control ☐ Increased Stability
☐ Increase Muscle Movement ☐ Increased Comfort

Comments: ______________________

Liner/Insert: ______________________

Rationale:
☐ Control Volume Change ☐ Increased Comfort
☐ Reduce Stress on Skin ☐ Improved Suspension

Comments: ______________________

Protective Cover: ☐ Yes ☐ No — ☐ Protect Internal Components ☐ Moisture Protection

Total Contact: ☐ Yes ☐ No — ☐ Increased Venous return ☐ Increased Wt. Bearing Surface ☐ Increased Comfort

MD Signature________________

General Observations and Comments:

MD Signature__________________

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: __________