Patient Information Sheet

HUMAN DESIGNS
PROSTHETICS AND ORTHOTICS

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

HUMAN DESIGNS
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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