



## PATIENT INFORMATION

<b>PATIENT INFORMATION</b>	PATIENT NAME: _____ ADDRESS: _____ HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____ EMERGENCY PHONE: _____ EMAIL ADDRESS: _____ SS #: _____ GENDER: _____ MARITAL STATUS: _____ DOB: _____
<b>PHYSICIAN INFORMATION</b>	REFERRING PHYSICIAN: _____ PHONE: _____ PRIMARY CARE PHYSICIAN: _____ PHONE: _____
<b>PRIMARY INSURANCE</b>	
<b>SECONDARY INSURANCE</b>	
<b>Worker's Comp Insurance</b>	Claim #: _____ Date of injury #: _____
<b>HIPAA</b>	<ul style="list-style-type: none"> <li>• <b>Notice of Privacy Practices:</b> You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, and the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you to read it carefully and completely before signing this Consent.</li> <li>• <b>Purpose of Consent:</b> By signing this form, you consent for South County Artificial Limb Co, Inc. to use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations</li> </ul>
<b>MEDICARE SUPPLIER STANDARDS</b>	"The products and/or services provided to you by South County Artificial Limb Co, Inc. are subject to the supplier standards contained in the Federal regulations shown at 42 Code of Federal Regulations Section 424.57(c). These standards concern business professional and operational matters (e.g., honoring warranties and hours of operation). The full text of these standards can be obtained at <a href="http://ecfr.gpoaccess.gov">http://ecfr.gpoaccess.gov</a> . Upon request we will furnish you a written copy of the standards."
<b>ASSIGNMENT OF BENEFITS</b>	I authorize my insurance company to pay benefits directly to South County Artificial Limb Co, Inc.. I understand my insurance company may not pay for services that are not a covered benefit or are not considered medically necessary. I also understand that there may be benefit limitations with no-fault carriers as deductibles and benefit maximums may apply. I agree to be financially responsible for all services provided by South County Artificial Limb Co, Inc.
<b>SIGNATURE</b>	<b>I HAVE READ, UNDERSTOOD, AND HEREBY AGREE TO ALL OF THE TERMS STATED ABOVE.</b>  _____ PATIENT OR AUTHORIZED REPRESENTATIVE SIGNATURE: _____ DATE: _____