CAROLINA PROSTHETICS & ORTHOTICS, INC.
110 LINER DR., GREENWOOD, SC 29646
864-942-7001

Patient Name: _____ Date of Birth: _____
First Name MI Last Name

Home Address: _____ City: _____ State: _____ Zip: ____
Home Phone: _____ Cell Phone: _____
Employer: _____ Work Phone: _____
Employer's Address: _____

City: _____ State: _____ Zip: _____
Spouse/Parent/Guardian: _____ Phone: _____
Emergency Contact: _____ Phone: _____
Height: _____ Weight: _____
Are you Diabetic? ____ Yes ____ No Diabetic Physician: _____ Phone: _____
Gender: ____ Female ____ Male Marital Status: ___ Married ___ Single ___ Divorced ___Widow____
Social Security Number: _____
Referring Physician's Name: _____ Phone: _____
Have you had a brace or artificial limb in the past 5 years? ____ Yes ____ No If so, from what Co._
Is injury related to: ___ Work ___ Auto ___ Other ___ Accident ___ N/A Date of Injury: _____
Employer at time of injury: _____ Phone: _____
Worker's Compensation Insurance Name: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: ____
Claim Number: _____ Adjuster: _____

**PLEASE PRESENT YOUR INSURANCE CARD(S) TO THE FRONT DESK SO THAT WE MAY MAKE COPIES FOR OUR RECORDS**

---

I certify that the information provided by me is true, accurate, and complete.
Signature of Patient: _____ Date: _____
Signature of Responsible Party: _____ Date: _____
Responsible Party's Relationship to Patient: _____

# Acknowledgement of Receipt of Notice of Privacy Practices, Medicare Standards for DMEPOS Suppliers, and HIPPA Financial Statement

I certify that I have been offered a full copy and received an overview to sign of Carolina Prosthetic & Orthotics, INC Notice of Privacy Practices, and Medicare Standards for DEMPOS Suppliers. I have access to a full copy in the office as well at any time to read. The Notice of Privacy Practices 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 Carolina Prosthetics & Orthotics, INC health care operations. The Notice of Privacy Practices also describes my rights and Carolina Prosthetics & Orthotics, INC duties with respect to my protected health information. Carolina Prosthetics & Orthotics, INC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or by asking for one at the time of my next appointment.

Clearance by the insurance carrier does **not guarantee** payment. Payment is subject to review after claim is received by the carrier. As the financial responsible party, I understand and agree to pay for these services if they are not covered/paid by the carrier.

_____

Signature of Patient or Personal Representative

_____

Name of Patient or Personal Representative

_____

Date

_____

Description of Personal Representative's Authority

_____

I Decline at this Time to Receive a Copy of the Privacy Practices of Carolina Prosthetics and Orthotics, INC.

**Patient Signature and Date**

# AUTHORIZATION TO RELEASE RECORDS AND FILES

I hereby authorize and request _____ to furnish to
*(Organization to release information)*

**CAROLINA PROSTHETICS & ORTHOTICS,** 303 W Alexander Ave Ste H, Greenwood, SC 29646,

regarding: _____
(Patient name)

_____
(Social Security Number) (Address at time of treatment)

All medical information of every kind and nature, consultations, and any and all material Concerning any history, examination, treatment, evaluation and/or, hospitalizations for the periods from _____.
(Dates of services)

I have been fully advised of my rights under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and I intend for this authorization to satisfy the requirements of "HIPAA" and the rules and regulations thereof. In that regard, I certify that I consent to the release of my records to Carolina Prosthetics & Orthotics, that the purpose of this request is for Carolina Prosthetics & Orthotics to file my Insurance claim, and that the release of my entire medical record is the minimum disclosure authorized by this request.

I, _____, have read the above and do authorize and consent for _____ to disclose the said information. I understand that this consent may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it or as otherwise specified by law. No individual has coerced me into signing this authorization and I am providing this authorization on my own free will. I understand that once this information is received by the authorized individual/organization, then this information may be subject to redisclosure, and may no longer be protected by federal privacy laws. I acknowledge that I have a right to revoke this authorization in writing by contacting the above named health care provider.

_____ _____
Date (Signature of Patient or Legal representative)

_____
(Witness)

Unless otherwise revoked, this authorization will expire on the following date, event or conditions: _____. If no date is specified, this authorization will expire in six months from this date of signature.