Patient Information Sheet

Patient's Name (Last, First): _____

Home Address (out of state if applicable): _____

City: _____ **State:** _____ **Zip:** _____

Mailing Address (local): _____

City: _____ **State:** _____ **Zip:** _____

Patient Status: ☐ **Single** ☐ **Married** ☐ **Other**

Home Phone: _____ **Cell Phone:** _____

Work Phone: _____ **E-mail address:** _____

Social Security #: _____ **Date of Birth:** _____

Emergency Contact Name: _____ **Relation to patient:** _____ **Phone:** _____

Responsible Party

Name (Last, First): _____ Relationship to Patient: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ E-mail Address: _____

Social Security #: _____ Date of Birth: _____

Insurance Information

Primary Insurance:

Phone Number: _____

Claims Address: _____

Policy Number: _____

Group Number: _____

Secondary Insurance Information: <u>You must check one box.</u>

☐ **<u>I DO NOT have Secondary Insurance; therefore, I accept financial responsibility for the secondary portion of my claim.</u>**

☐ **<u>YES, I DO have Secondary Insurance</u>**

Phone Number: _____

Claims Address: _____

Policy Number: _____

Group Number: _____

Benefits, Medical Information Release Authorization and Acknowledgment of Financial Responsibility:

I request my insurance benefits, if any, be paid directly to the provider. I authorize the release of any information necessary to provide services or process claims. As the responsible party, I understand that I am personally responsible for the entire amount of my claim and that insurance benefits may be limited or non-existent. I agree to notify Arise Prosthetics immediately of any change in my insurance coverage or status. I understand I am financially responsible for all charges not covered by my insurance. In the event of default, I agree to pay up to a 50% fee added to unpaid balances that require a collection agency. I also to pay court costs, interest allowed by law and attorney fees incurred because of the default.

Signed: _____ **Date:** _____