ROYAL Orthotics LLC

"Where family matters"

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NEW PATIENT REGISTRATION

Patient's First Name:	MI:	Last Name:	Gender ☐ M ☐F	Marital Status ☐S ☐M ☐D ☐W
Permanent Street Address:		City:	State:	Zip Code:
Home Telephone # ( )	Cell Phone # ( )		DOB: / /	

Employment Information of patient

Your Employment Status — Employer Name:

☐ Full Time ☐ Part Time ☐Retired ☐Unemployment ☐Student ☐Other

Your Spouse/Parent's Employment Status — Employer Name:

☐ Full Time ☐ Part Time ☐Retired ☐Unemployment ☐Student ☐Other

Primary Insurance Information

Are you the insured? ☐ Yes ☐ No

Is this a work injury? ☐ Yes ☐ No

Name of Insurance Company:	Insurance phone #	Relationship to the insured:
Insurance ID #	Insurance Group #	Insurance Plan #
Insured's Name (if NOT the patient):	Insured's DOB:	Social Security # of the Insured: - -

Other Insurance Information

Is the spouse the insured? ☐ Yes ☐ No

Are you on this plan? ☐Yes ☐ No

Name of Insurance Company	Insurance phone #	Relationship to the insured:
Insurance ID #	Insurance Group #	Insurance Plan #
Insured's Name (If NOT the patient):	Insured's DOB:	Social Security # of the insured:

Diagnosis:				Referring Physician:	
Height:	Weight: lbs.	○ ○	○ ○	Allergies? ☐ Yes ☐No	If yes, what kind? ☐Latex ☐ Other
Recent Surgeries? ☐ Yes ☐ No	Any physical therapy? ☐ Yes ☐ No		☐ Yes ☐ No		☐ Yes ☐ No

I certify that the information provided on this Patient Registration form is true and accurate.

I have also read the patient consent, and acknowledgment form on the reverse side.

Patient's Signature:	Patient's Printed Name:	Date:
Representative's Signature:	Representative's Printed Name:	Date:

PATIENT CONSENT, AUTHORIZATION & ACKNOWLEDGEMENT FORM

NAME OF DMEPOS SUPPLIER			DMEPOS SUPPLIER'S NPI NUMBER	
Royal Orthotics				
PATIENT FIRST NAME	MI	LAST NAME	DATE OF BIRTH	MEDICAL RECORD #

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I have been given a copy of this DMEPOS Supplier's Notice of Privacy Practices and understand the DMEPOS Supplier's rights, and my patient rights relating to my protected health information (PHI). I hereby consent and grant permission for this DMEPOS Supplier and any Employees employed by this DMEPOS Supplier to discuss my medical treatment for orthotics and/or prosthetics, with my referring physician, primary care physician, physical therapist, occupational therapist, hospital and/or rehabilitation staff, relating to my care and plan of treatment. I also understand that I have rights to place restrictions on how my protected health information is used or disclosed. I also understand that it is my responsibility to notify the DMEPOS Supplier's Privacy Officer, in writing of any restrictions to my patient file and protected health information (PHI). Forms are available at the front desk and through the Privacy Officer upon patient request.

CONSENT TO TREAT, OFFICE PROCEDURES & PATIENT RESPONSIBILITY

I hereby give consent for this DMEPOS Supplier to provide treatment and service(s) the assigned Provider may deem necessary, as ordered by my physician(s). I understand that I am responsible for payment of charges for services rendered, and that payment is due at the time of service, and/or I hereby assign insurance benefits to be paid directly to this DMEPOS Supplier for professional fees for services rendered to me. I further understand that I am responsible for charges not covered by my insurance policy. I understand that any amounts which are _____ days past due could be eligible for potential collections and turned over to a Collection Agency, unless prior arrangements have been made with the DMEPOS Suppliers administrator and/or billing staff. Collection Agency fees are recognized to be my (*the patient/responsible party*) responsibility. I understand that I am responsible for a fee of $_____ for any returned check.

CONSENT TO PHOTOGRAPH AND/OR VIDEO

I, hereby consent and authorize to be photographed and/or videotaped by this DMEPOS Supplier, for promotional, advertising, training, & education purposes about orthotic and/or prosthetic services, medical equipment, medical items and/or treatment outcomes in professional medical journals, periodicals, newspapers, our company's website, company brochures and other marketing materials. I understand that use of patient photograph(s) and/or videotape(s) may be used to educate, train and/or promote awareness to parents, staff and other professional healthcare providers. I understand that the original print(s), negative(s) and/or video(s) will be maintained and stored in the patient's medical record at the physical office location of this DMEPOS Supplier**.** All such original print(s), negative(s) and/or video(s) will be the exclusive property of this DMEPOS Supplier**.** I understand that I have the option to withdraw my consent and I have the right to do so at any time. I understand that I must submit my option to withdraw this consent by sending a letter directly to the administrative offices of this DMEPOS Supplier. I further release this DMEPOS Supplier and its Board of Directors, Officers, Employees and Representatives from any and all liability regarding these photograph(s) and/or videotape(s), and I understand that there will be no financial or other payment for the use of these photographic image(s) and/or videotape(s).

RELEASE OF INFORMATION & AUTHORIZATION

I hereby consent and permit a copy of this authorization and assignments to be used in place of this original signed document. I understand that this original will be placed in my patient file and stored at this DMEPOS Supplier's office. I hereby authorize this DMEPOS Supplier that is examining and/or treating me, to release to any third party (*such as an insurance company or governmental agency*) any medical information and records concerning the diagnosis, plan of treatment and/or treatment when requested for use in determining payment of claims. I understand that this is a Lifetime Release of Information unless I have placed restrictions in my patient file and protected health information (PHI) and have completed the necessary HIPAA PHI forms. I hereby consent and authorize this DMEPOS Supplier to file medical claims for treatment, electronically or manually, to my insurance carrier(s), Medicare and/or Medicaid, for services professional services rendered to me.

ASSIGNMENT OF BENEFITS

I hereby consent and authorize payment to be paid directly to this DMEPOS Supplier from my primary insurance, secondary insurance, workers compensation payer and/or any other type of payer for which I am insured, for professional services rendered to me, for any orthotic and/or prosthetic services and treatment. Any services and/or treatment for which assignment is not accepted are acknowledged as being my full and complete financial responsibility.

Returns:

I understand and agree to have braces made by Royal Orthotics and that once braces are made they are not returnable for return of insurance payments.

By signing this consent form, I confirm that I have read, understand and agree to all terms and conditions. I also represent that I am over the age of 18 years of age and/or I am at the parent or legal guardian of the above mentioned minor. I understand that I may request and receive a copy of this consent form for my personal records.

_____	_____	_____
Patient's Signature:	Patient's Printed Name:	Date Signed
_____	_____	_____
Legal Guardian/Representative's Signature:	Legal Guardian/Representative's Printed Name:	Date Signed

Please describe your legal authority to act on the patient's behalf:_____