PATIENT INFORMATION

REFERRING PHYSICIAN______________________________

LAST NAME ____ FIRST ____ MIDDLE ____ HOME PHONE NUMBER ____

ADDRESS ____ APT# ____ CITY ____ STATE ____ ZIP ____

DATE OF BIRTH ____ AGE ____ SOCIAL SECURITY NUMBER ____ SEX ____ MARITAL STATUS ____ HEIGHT ____ WEIGHT ____

EMPLOYER ____ OCCUPATION ____

EMPLOYER ADDRESS ____ EMPLOYER PHONE ____

SPOUSE / PARENT / GUARDIAN/IF PT UNDER AGE ____ DATE OF INJURY / ILLNESS / ACCIDENT (CIRCLE ONE) ____

RELATIVE OR FRIEND ____ RELATIONSHIP ____ PHONE NUMBER ____

INSURANCE INFORMATION

MEDICARE MEDI-CAL HMO PPO PRIVATE CASH CCS VA W/C OTHER

INSURANCE COMPANY ____ PHONE NUMBER ____

SUBSCRIBER / IINSURED'S NAME (IF OTHER THAN PATIENT)DATE OF BIRTH ____ RELATIONSHIP TO PATIENT ____ SOCIAL SECURITY NUMBER ____

SUBSCRIBER'S – EMPLOYER (IF WORK COMP EMPLOYER AT TIME OF INJURY) ____ DATE OF INJURY ____ CLAIM NUMBER ____

CARRIER – NAME AND ADDRESS ____ ADJUSTER NAME ____

SECONDARY CARRIER (IF NECESSARY) ____

PLEASE READ AND SIGN THE FOLLOWING

I hereby authorize Orthotic / Prosthetic services prescribed by my physician. I hereby authorize SCOPe to furnish my insurance company with all the information they request. I also instruct my insurance company to pay my claim directly to SCOPe. I also grant SCOPe permission to call me in order to schedule, confirm, or reschedule an appointment.

I understand that if my insurance requires authorization and I choose to receive service before that written authorization has been received by SCOPe, that I will accept financial responsibility for all charges. I understand that authorization is not a guarantee of payment, but only a guarantee of medical necessity by my insurance. I also understand that even if services are authorized, that if 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 may be responsible for payment in full. I further understand that my insurance company may deduct a CO-PAY, COST SHARE or DEDUCTIBLE from their payment to SCOPe, and I agree to pay PROMPTLY for these amounts. If my balance remains outstanding for more than 90days, my account will be subject to interest charges. Any interest will accrue at 1.5% monthly (18% annually). I understand that I will be responsible for payment of any interest charges. I also understand that if I am delinquent in my financial responsibility, SCOPe may refer my account to a collection agency and I will be held financially responsible for such collection fees.

I understand that items received may not be returned or payments refunded in order to reduce my financial responsibility.

PATIENT OR LEGAL GUARDIANS SIGNATURE ____ DATE ____