



PATIENT INFORMATION

ACCOUNT No. _____

LAST NAME	FIRST	MIDDLE	SOCIAL SECURITY NUMBER
ADDRESS	APT#		HOME PHONE NUMBER
CITY	STATE	ZIP	CELLULAR PHONE NUMBER

DATE OF BIRTH	AGE	HEIGHT	GENDER	WEIGHT	MARITAL STATUS	DATE OF INJURY / ILLNESS / ACCIDENT (CIRCLE ONE)
REFERRING PHYSICIAN			EMAIL ADDRESS			
PATIENT'S EMPLOYER (IF N/A, STATE REASON)			OCCUPATION		EMPLOYER PHONE	
IF PATIENT IS A MINOR: PARENT / GUARDIAN (CIRCLE ONE)			SOCIAL SECURITY NUMBER		DAYTIME PHONE NUMBER	
EMERGENCY CONTACT: SPOUSE / RELATIVE / OTHER (CIRCLE ONE)			HOME PHONE NUMBER		WORK / OTHER PHONE NUMBER	

INSURANCE INFORMATION MEDICARE MEDI-CAL CCS VA HMO PPO POS EPO CASH OTHER: _____

PRIMARY INSURANCE CARRIER	PHONE NUMBER	IDENTIFICATION / POLICY NUMBER
SUBSCRIBER NAME (IF OTHER THAN PATIENT)	DATE OF BIRTH	SOCIAL SECURITY NUMBER
SUBSCRIBER'S EMPLOYER	GROUP NUMBER	RELATION TO PATIENT
SUBSCRIBER'S EMPLOYER	GROUP NUMBER	EMPLOYER'S PHONE NUMBER
SECONDARY INSURANCE CARRIER (IF N/A, WRITE "NONE")	PHONE NUMBER	IDENTIFICATION / POLICY NUMBER

WORKMAN COMPENSATION INFORMATION

WORK COMP CARRIER NAME	ADJUSTER'S NAME	PHONE NUMBER
EMPLOYER AT THE TIME OF INJURY	DATE OF INJURY	CLAIM NUMBER

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. Any overpayment not related to an insurance company will be refunded to the subscriber of the insurance regardless of who made the payment.

PATIENT OR LEGAL GUARDIANS SIGNATURE	DATE
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