PATIENT INFORMATION PATIENT ACCT #_____

NAME:_____ Social Security# ___-___-_____ **Date of Birth:** _____

Home Phone:(___) _____Work Phone:(___)_____Other Phone(___)_____Email:_____

Address: _____PO Box: _____ City: _____ State: _____ Zip:_____

Sex: ___Female ___ Male Marital Status: S M W D Height _____ Weight _____ Shoe Size: _____

Do you reside in a Nursing Facility ☐ No - ☐ Yes, **Admit Date** _____ **Name of facility:**_____

Referring Doctor:_____**Family Doctor:**_____**Diabetic:** ___**Y** ___**N Diabetic Doctor:**_____

Did you have a face to face appointment with your doctor on date that prescription was written? ____**Y** ____**N**

RESPONSIBLE PARTY OR GUARANTOR (Who is responsible for payment of bill)

NAME _____ Social Security # _____
Home Phone:(___)_____ Work Phone: (___)_____Message Phone:(___)_____
Address:_____ PO Box: _____
City: _____ State:_____Zip:_____Date of Birth:_____Sex:_____ Marital Status: S M W D

AUTO _____ **OR WORK COMP** _____ **Accident/Injury Date:**_____
Claim# :_____ Adjuster Name: _____Phone# _____

INSURANCE INFORMATION (We will make copies of your insurance cards)

Primary Ins: _____ Secondary Ins._____
Subscriber Name:_____Birthdate:_____ Subscriber Name:_____Birthdate:_____
Group # _____ Policy # _____ Group # _____ Policy # _____

Patients: Have you received a brace of this type, or similar in the last 5 years? ____**YES** ____**NO Initials** _____

Date received? _____ **Where or what company did you receive item?**_____

** By initialing above, you are confirming that you understand that if you have received this type of device in the last 5 years and your insurance denies this claim, that you may be held financially responsible for the costs of the delivered device/item.

All patients will incur a 15% restocking fee if item (s) are returned or not picked up within 30 days of delivery notification. ____**Init.**

Benefits, Medical Information Release Authorization and Acknowledgment of Financial Responsibility:
I request my insurance benefits, if any, be paid directly to Teter o&P, Inc. I authorize the release of any information necessary to provide service or process claims OR appeal my claim. As the responsible party, I understand that I am personally responsible for the entire amount of my claim and any amounts not covered by my insurance plan or any amounts remaining after my insurance plan has made payment, including all deductibles, co-payments and coinsurance. There will be a $25.00 fee assessed for all returned checks. A collection agency and/or small claims court will be utilized for accounts that are deemed not collectable. **(If over 18 & your parents are paying, we must have their signature to bill them)**

Signature of Patient or Responsible Party:_____**Date:**_____

Teter O & P has my authorization to provide medical or billing information to: _____

Relationship:_____**Signed:**_____ **Date:**_____

Do we have your permission to contact you for new services? _____***YES*** _____***NO*** ***Updated 07/15/15***