BIO Prosthetic-Orthotic LAB

POST OP PATIENTS – CALL OUR OFFICE IMMEDIATELY TO SET UP AN APPOINTMENT FOR DELIVERY: (703) 726-4092, Fax: (703) 726-4095

(REVISED 4/20/09)

Patient Information

Primary Language_____
Patient's LastName:_____First:_____Mid.Inl:___
Patient's Weight _____ Patient's Height_____Patient's Shoe Size_____
Patient's Street Address:_____
City:_____ State:_____ Zip code: _____
Patient's Home Phone#____-____-_____ Cell #_____-_____-_____
Patient's/Parent's Email: _____
Patient's DOB ___/___/___ Patient's Sex: M/F Status: M S D O
Patient's Diagnosis:_____ Patient's Relation to Insured_____
Mother's Name: _____Day Time#:_____-_____-_____
Father's Name:_____ Day Time#:_____-_____-_____
Emergency Contact not in the home:_____Day Time#:____-___

Patient's Insurance Information

Name of Primary Insurance: _____
Address of Insurance:_____
City:_____State:_____Zip code:_____
Insurance Phone #:_____ Employer:_____
Policy Holders Name:_____ DOB:___/___/____sex: M/F
Policy Holders Social Security#_____-____-_____
Policy Group/Plan#:_____ Identification#:_____

Name of Secondary Insurance: _____
Address of Second Insurance:_____
City:_____State:_____Zip Code:_____
Insurance Phone#:_____Employer:_____
Policy Holders Name:_____DOB:___/___/____Sex: M/F
Policy Holders Social Security#:_____-____-_____
Policy Group/Plan#:_____ Identification#: _____

Medical Resources

Prescribing Doctor:_____
Primary Care Doctor:_____ Physical Therapist:_____
Patient's School:_____ Phone#:_____
Contact at School:_____

OUR OFFICE WILL DO ITS UTMOST TO OBTAIN YOUR MAXIMUM INSURANCE BENEFIT, BUT FEE FOR SERVICE IS YOUR RESPONSIBILITY, AND PAYMENT IS EXPECTED REGARDLESS OF INSURANCE COVERAGE.

OVER →

+Financial Responsibilities

I understand that work on the orthosis or prosthesis will not be started until all necessary paperwork has been turned into the main office in Ashburn, VA, ph. 703 726-4092, fax 703 726-4095

I certify that the above information is true and correct to the best of my knowledge. I will notify Bio Lab immediately of any changes in my health insurance coverage or any of the above information.

I understand and agree that regardless of the status of my insurance, I am ultimately responsible for my deductible, co-pays, and any balance and interest on my account for any professional services rendered to the above named patient. **In the event that any fees for services or products are not paid for by insurance, the undersigned financially responsible party shall bear full financial responsibility for all reasonable costs set forth by this agreement.**

I further authorize that any insurance benefits that are reimbursable for such services be paid directly to Bio Prosthetic Orthotic Lab, Inc., for services rendered. I consent to the release of any medical information that may be required to verify the justness of any claim made as a result of these services and payment thereof.

I certify that I have received a copy of Bio Lab's Notice of Privacy Practices which describes the types of uses and disclosures of my health information for my treatment and payment of my bills.

I understand that with the exception on accounts covered by DC/MD Medicaid, Maryland Children's Medical Services, or Kiwanis in full, all bills not paid in sixty (60) days will bear interest at the rate of 18% per year. **In the event that Bio Prosthetic Orthotic Lab Inc. must pursue Collection Actions, I accept responsibility for the balance due plus all interest charges, attorney's fees and court/collection cost.**

I authorize use of this form on **ALL** my insurance submissions.
I authorize release of information to all my **INSURANCE COMPANIES.**
I authorize Bio Lab or its billing company to act as **MY** agent in helping me obtain payment from my insurance companies both now and in the future until I revoke this permission in writing.
I authorize payment direct to Bio Lab (Bio Prosthetic Orthotic Lab).
I permit copies of this authorization to be used in place of the original.

I authorize release of pertinent information from my doctor so as to get insurance coverage, including but not restricted to, historical and clinical notes.

I understand that I AM the RESPONSIBLE party for this bill.

Signature:_____Date:_____

Printed Name:_____

Self ___ Parent or Guardian ___