SOUTHEASTERN
ORTHOTICS & PROSTHETICS

For Office Use Only: Account #:_____

CONSENT and PREFERENCE for Healthcare Messaging

These forms MUST be fully completed

Name: _____

My Email Address: _____

My Phone Number: _____

Email and Text Messaging Consent

I hereby state my preference to have Southeastern(SEOP) practitioners and staff communicate with me by email or standard SMS (text) messaging regarding prescriptions, appointments, reminders, and billing. I understand that email and SMS messaging are not confidential and there is a risk that e-mail and SMS messaging might be intercepted and read by a third party. I also understand that I may withdraw this consent at any time by resubmitting this form to SEOP.

I consent to email/text messaging communication ☐ Yes ☐ No

I prefer to receive my appointment reminders in the following method ☐ Text ☐ Email

I authorize SEOP to discuss my healthcare as indicated with the following individual:

Name: _____

Relationship: _____

Phone: _____

☐Yes ☐ No Appointment Reminders ☐ Yes ☐ No Billing Information

_____ _____

Patient or Guardian Signature Date

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PATIENT INFORMATION ***(Please Print All Information)*** Date: _____

Last Name: _____First Name:_____MI:_____

Street Address: _____Apt #:_____City: _____

State: _____ Zip Code: _____ Phone #1: *Cell/Home/Work/Other:* (_____)_____

Date of Birth: _____ Phone #2: *Cell/Home/Work/Other:* (_____)_____

Male: ☐ Female: ☐ Marital Status: Single ☐ Married ☐ Divorced ☐

Social Security #: _____-____-_____ Widowed ☐ Other ☐

RESPONSIBLE PARTY ***(if patient is a minor, please complete this section)*** ***Self/Same as above:*** ☐

Last Name: _____First Name:_____MI:_____

Street Address: _____Apt #:_____City: _____

City:_____State: _____ Zip: _____ Birth Date: _____Age: ____

Male: ☐ Female: ☐ Social Security #: _____ - _____ - _____

Email Address: _____ Relationship to Patient: _____

ACKNOWLEDGEMENT OF RECEIPT

I certify that I have received a copy of the Southeastern(SEOP) Notice of Privacy Practices and Patient Bill of Rights, Medicare Supplier Standards, Warranty Information, Mission Statement and Patient Responsibilities contained in the patient brochure.

X_____ _____

Patient/Guardian Signature **Date**

RETURN POLICY

Federal Law PROHIBITS re-use of medical supplies and equipment. Therefore, SEOP cannot accept any prescribed items for return or refund except in cases of manufacturer defects.

ASSIGNMENT OF BENEFITS

I hereby assign all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and any other health/medical plan, to issue payment directly to Southeastern, a division of Restorative Health Services Group for services rendered to myself and/or my dependents.

PAYMENT AGREEMENT

I agree that in the event my insurance or other third-party payor refuses to pay the rental or purchase price of the equipment or service, that I will be responsible for those payments. If for any reason my account should become delinquent, I agree to pay for all billing charges, interest charges, collection fees, and reasonable legal fees. Collection calls may be made to any phone number (including cell phone numbers) that you have provided to us. I give permission for SEOP to contact me by mail, phone, or voice mail message, to schedule, re-schedule, or remind me of appointments or to inform me of any insurance carrier information pertinent to my service or products being rendered.

RELEASE OF INFORMATION

I authorize any of my medical providers to release to SEOP any information including protected health information (PHI) necessary for the purpose of preauthorizing or billing services or goods received at SEOP. I further authorize SEOP to release medical records to my referring medical provider(s). I understand that this PHI will not be used for any other purposes other than outlined above and will be subject to all HIPPA rules and regulations concerning personal health information. I also understand this release is valid as long as I am under the care of the practitioners of SEOP unless revoked by written request.

X_____ _____

Patient/Guardian Signature **Date**

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INSURANCE INFORMATION *(Please complete this section & hand your card(s) to the receptionist.)*

Policy Holder Name: Self ☐ or OTHER _____

Policyholder Date of Birth: _____ Relationship to Patient: _____

Pediatric Patients: Is your child enrolled in TN Early Intervention Services? _____ ID#: _____

SECONDARY INSURANCE INFORMATION

Policy Holder Name: Self ☐ or OTHER _____

Policyholder Date of Birth: _____ Relationship to Patient: _____

WORKERS COMPENSATION / LIABILITY INSURANCE **MVA / LIABILITY CLAIMS – Please be advised that you are responsible for payment of all services; Payment cannot be withheld pending a settlement of your claim. WORKERS COMP. – Please be advised that we may bill your employer for any under paid or pending claims.*

Claim Number: _____ Date of Injury: _____-_____-_____ Place of Injury: _____

Employer at Time of Injury: _____ Employer Phone #: _____

Claim Adjuster: _____ Phone #: _____

MEDICAL INFORMATION *(Please Complete This Section Fully)*

Referring Physician: _____ Phone #: _____

Primary Care Physician: _____ Phone #: _____

Were you injured in an automobile accident? Yes ☐ No ☐
Is your condition due to a work-related injury? Yes ☐ No ☐
Have you had a brace or artificial limb in the past 5 years? Yes ☐ No ☐
Are you Diabetic? Yes ☐ No ☐

PROSTHETIC PATIENTS: Left ☐ Right ☐ Below Knee ☐ Above Knee ☐ Upper Extremity ☐

Date of Amputation: _____ Surgeon who performed Amputation: _____

MEDICAL HISTORY: Height: _____ft. _____in. Weight: _____lbs.

Are you currently residing in a nursing home/or are you going to be residing in a nursing facility within the next 30 days: Yes☐ No☐ If yes, Facility Name: _____

Activity level: Low ☐ Medium ☐ High ☐ Highly Active ☐

How would you describe your general health? Poor ☐ Fair ☐ Good ☐ Excellent ☐

Attending Therapy? Physical ☐ Occupational ☐ Both ☐

Therapist: _____ Phone #: _____