Patient Registration

Patient Name _____ **Date of Birth** _____

Social Security No. _____ Home Phone No. _____

Work Phone No. _____ Cell Phone No. _____

Home Address _____

City_____ State _____ Zip _____

Referred By _____ **Primary Care Physician**_____

Employed (Check One) Yes _____ No_____ Employers Name_____

Address _____ City _____ Zip _____

Work Telephone No. _____ Is This Work Related? Yes _____ No _____

If yes; date of injury _____ Work Comp Co _____

Spouse's Name _____ Occupation _____

Emergency Contact _____ Relationship_____ Phone No._____

Primary Insurance (Name of Company) _____

Name of Insured _____ Relationship to Insured_____

Policy No. _____ Group No._____

Secondary Insurance (Name of Company) _____

Name of Insured _____ Relationship to Insured_____

Policy No. _____ Group No._____

Any Known Allergies_____

Assignment of Benefits/Release of Information

I hereby give lifetime authorization for payment of insurance benefits to be paid directly to practitioners of Bionics Orthotics and Prosthetics for services rendered. I hereby authorize practitioners to release all information necessary to process the services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. I further understand that any overpayment of professional services to the practitioner will be reimbursed to me after the bill has been paid in full. In the event of default I agree to pay all costs of collections and reasonable attorney's fees. I further agree that a photo copy of this agreement shall be valid as the original

Patient's Signature _____Date _____

BIONICS ORTHOTICS & PROSTHETICS
FINANCIAL POLICY

Thank you for choosing BIONICS ORTHOTICS & PROSTHETICS as your health care provider. We are committed to your treatment being successful. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment. All patients must complete and sign our Patient Information and Financial Policy form before seeing the practitioner. Please understand that payment for your bill is considered a part of your treatment.

Regarding your Insurance: Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We may or may not choose to accept assignment of your insurance benefits. We cannot bill your insurance unless you give us your most current insurance information. **Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance.** If the treatment is not a covered benefit under your policy, the balance will become due and payable by you at the time of delivery. **We accept cash, check, money order and Visa/MasterCard.**

Regarding insurance plans where we are not a participating provider: We will notify you in advance if we are not a participating provider. Please be aware that your insurance company may choose not to render payment if you do not have out-of-network benefits. We will notify you at the time of service if this option is available under your plan. If so, there is a chance that your out-of-pocket may be higher than that of a participating provider.

Usual and Customary Rates/Payment Recovery: Our practice is committed to providing the best treatment for our patients. We charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. I also agree that, in the event I fail to fulfill my financial obligation, I will bear the cost of collection and/or court costs and reasonable legal fees should such action be required. I further agree that a photocopy of this agreement shall be valid as the original.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. I have read the Financial Policy. I understand and agree to this Financial Policy.

_____ _____

Signature of Patient or Responsible Party Date