## INFORMATION DISCLAIMER

In order for Abana Orthotics & Prosthetics to file your insurance, we must have the following information and agreements on file.

1. I agree to have any medical records or doctors' reports released to Abana Orthotics & Prosthetics for treatment, billing and/or collection purposes.

2. I agree that any insurance payment may be made directed to Abana Orthotics & Prosthetics.

3. I agree and understand that Abana Orthotics & Prosthetics will bill my insurance as a courtesy to me and that in the event my insurance or third-party payer does not cover my financial responsibility that I will be responsible for all or any part of the charges.

## PAYMENT REQUIREMENTS

## FOR NO INSURANCE, NON-COVERED SERVICES, OR CUSTOM-MADE ITEMS

A Deposit of $50.00 or 40% of the total charges (using the greater amount) is due at the time of service on:

1. Any item not covered by insurance.

2. Any item ordered for a patient without insurance.

3. Any patient that has a deductible still not met.

4. Any custom-made item your insurance will not cover.

(Deposits for custom-made items are NOT REFUNDABLE)

I HAVE READ AND UNDERSTAND ALL OF THE ABOVE.

Signed_____ Date_____

Patient or Responsible Party Signature

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## PATIENT INFORMATION

Patient Name:_____ Date of Birth:_____ Social Security Number:_____

Address:_____ City:_____ State:_____ Zip Code:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Email:_____ ☐Male ☐Female ☐Married ☐Single ☐Divorced ☐Widowed

Employed: ☐Yes ☐No Employed by:_____

City:_____ State:_____ Zip Code:_____

## RESPONSIBLE PARTY INFORMATION

Patient Name:_____ Date of Birth:_____ Social Security Number:_____

Address:_____ City:_____ State:_____ Zip Code:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Email:_____ ☐Male ☐Female ☐Married ☐Single ☐Divorced ☐Widowed

Employed: ☐Yes ☐No Employed by:_____

City:_____ State:_____ Zip Code:_____

## PHYSICIAN INFORMATION

Primary Care Physician's Name: _____ City:_____

Surgeon's Name: _____ City:_____

Specialist Name: _____ City:_____

Other: _____ City: _____ Explain: _____

## AMPUTATION INFORMATION

**Are you Amputee?** ☐ Yes ☐ No (If yes complete below)

☐ Shoulder Disarticulation ☐ Above Elbow ☐ Below Elbow ☐ Wrist Disarticulation

☐ Below Knee ☐ Above Knee ☐ Hip Disarticulation ☐ Symes (Ankle) ☐ Partial Foot

Was your amputation a result of: ☐ Accident ☐ Illness ☐ Birth Defect

Date of Amputation: _____ Physician that performed amputation: _____

Hospital where performed: _____ City where performed: _____

Primary Physician at the time: _____ City: _____

Explain what led to your amputation: _____

## ACCIDENT INFORMATION

**Is your condition the result of an accident?** ☐ Yes ☐ No (If yes complete below)

Date of Accident: _____ Work related: ☐ Yes ☐ No Auto related: ☐ Yes ☐ No

Workman's Comp Carrier: _____ Case Manager: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Claim Number: _____ Explain Accident: _____

Have you retained an Attorney in relation to this injury? ☐ Yes ☐ No

## PRIMARY INSURANCE

Insurance Name: _____ ID #: _____ Group #: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Is Prior Authorization Required: ☐ Yes ☐ No

Insured's Name: _____ Address: _____ City: _____ State: _____ Zip: _____

Relationship to Patient: _____ Insured's Date of Birth: _____

## SECONDARY INSURANCE

Insurance Name: _____ ID #: _____ Group #: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Is Prior Authorization Required: ☐ Yes ☐ No

Insured's Name: _____ Address: _____ City: _____ State: _____ Zip: _____

Relationship to Patient: _____ Insured's Date of Birth: _____

Abana Orthotics & Prosthetics

**Patient Evaluation**

(Revised 02/23/2010)

Patient Name: _____

DOB: _____ Weight: _____

☐ Male ☐ Female

**Has your insurance changed in the last year?**

☐ Yes ☐ No If yes we need copies of your cards.

## Pertaining to the service you will receive today.

**Have you received the same or similar item?**

☐ Yes ☐ No ☐ Not Applicable

**Knee Brace in the last 3 years?**

☐ Yes ☐ No ☐ Not Applicable

**Back, Arm, Hip or Ankle Brace or Prosthetics in the last 5 years?**

☐ Yes ☐ No ☐ Not Applicable

**Cane, Crutch, and/or Walker in the last 2 years?**

☐ Yes ☐ No ☐ Not Applicable

**Diabetic Shoe's and/or Inserts in the last year?**

☐ Yes ☐ No ☐ Not Applicable

**Any item you're receiving today that is not included above?**

☐ Yes ☐ No ☐ Not Applicable

**If yes complete here:**

When did you receive it? _____

Who supplied this item? _____

In what city? _____

Did you? ☐ Purchased or ☐ Rent

**Primary Care Physician's**

Name: _____

City: _____

**Surgeon**

Name: _____

City: _____

**Specialist**

Name: _____

City: _____

**Is this the result of an accident?** ☐ Yes ☐ No

Work related? ☐ Yes ☐ No

☐ Auto ☐ Other

Accident date: _____

Description of Accident: _____

_____

_____

**Have you retained an Attorney in relation to this accident?**

☐ Yes ☐ No ☐ Not Applicable

**Do you live?**

☐ Home with assistance

☐ Home without assistance

☐ Skilled Nursing Facility

☐ Rehabilitation Hospital / Center

**Activity Level?**

☐ High ☐ Moderate ☐ Low ☐ Inactive

**Can you stand from sitting?**

☐ Yes ☐ No

**Do you require assistance to stand?**

☐ Yes ☐ No

**Assistive devices utilized by patient:**

☐ None ☐ Cane ☐ Walker ☐ Crutches

☐ Wheel Chair (Power or Regular)

☐ Prosthesis ☐ Orthosis (Brace)

**Have you had a recent weight change?**

☐ Yes ☐ No If yes, ☐ Loss _____ lbs ☐ Gain_____lbs

### Have you had or do you have?

☐ Allergies (list below)
☐ Alcoholism
☐ Amputation
☐ Arteriosclerosis
☐ Arthritis
☐ Asthma
☐ Back Pain
☐ Bleeding Tendencies
☐ Burns
☐ Cancer
(Type) _____
☐ Cerebral Palsy
☐ Diabetes
☐ Drug Addiction
☐ Heart Disease
☐ Hepatitis A, B, or C
☐ HIV
☐ Hypertension
☐ Hypotension
☐ Hearing Impaired
☐ Incontinence
☐ Internal Prosthesis
☐ Lung Disease
☐ Muscular Dystrophy
☐ Multiple Sclerosis
☐ Nerve Injury
☐ Osteoporosis
☐ Staph Infection
☐Scoliosis
☐ Sensation Loss
☐ Spinal Bifida
☐ Stroke
☐ Skin Problems
☐ Tuberculosis
☐ Vascular Disease
☐ Visual Impairment
☐ Other _____

List Allergies: _____

**Medications:**

_____ _____

_____ _____

_____ _____

_____ _____

The above information is true and correct to the best of my knowledge.

_____

Patient Signature Date

# ABANA ORTHOTICS & PROSTHETICS

**Please initial the following:**
**I acknowledge** receipt of/or have been offered a copy of the following information

_____ Company Financial Policy

_____ HIPPA (Notice of Patient Privacy Right)

_____ Medicare Supplier Standards

_____ _____
**Signature of Patient/Patient Representative** **Date**

## Communication Authorization

**I permit** Abana O&P to collect my health care information from my physician in order to receive payment for their services for my device.

**I authorize** Abana O&P to leave messages on my home phone/cell or contact me by e-mail at

_____

**I authorize** Abana O&P to discuss my protected health information in the presence of

_____

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This authorization shall be in force and effect for 5 years at which time this authorization to disclose protected health information expires. I also understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to the attention of the Office manager at the 1419 Peterman Dr. Alexandria, LA 71301 address.

_____ _____
**Signature of Patient/Patient Representative** **Date**

## Payment Authorization

_____ **I assign** the right and responsibility to Abana O&P to bill my insurance carrier on my behalf and accept payment for my device.

_____ **I authorize** my insurance carrier to make payment to Abana O&P.

_____ **I accept** responsibility for my coinsurance and my deductible on this device.

_____ **I** am aware that if services are not covered, I am fully responsible for all changes incurred for my services.

_____ _____
**Signature of Patient/Patient Representative** **Date**