Transcend
Orthotics & Prosthetics

Patient Intake Form

PATIENT INFORMATION

Last Name:	First Name:	Middle Name:	Suffix:
SSN:	DOB:	Gender:	Height:	Weight:
Mailing Address:	Preferred Language:
Physical Address (if different):
City:	State:	Zip Code:	County:
Primary Phone:	☐ Home	☐ Work	☐ Mobile	Okay to text? ☐ Yes ☐ No
Secondary Phone:	☐ Home	☐ Work	☐ Mobile	Okay to text? ☐ Yes ☐ No
E-mail:	I permit Transcend O&P to contact me through the e-mail address provided here. I understand that some Protected Health Information (PHI) may be shared in the content of these messages, and I understand that e-mail is NOT considered a secure method to transmit this information: ☐ Yes ☐ No **Initial**: _______________

CONTACT INFORMATION

Responsible Party	Last Name:	First Name:	Relationship to patient:		
	☐ Check if same as patient	Address:	City:	State:	Zip:
	Primary Phone:	☐ Home	☐ Work	☐ Mobile	E-mail:
Emergency Contact	Last Name:	First Name:	Relationship to patient:		
	☐ Check if same as patient	Address:	City:	State:	Zip:
	Primary Phone:	☐ Home	☐ Work	☐ Mobile	E-mail:

CLINICAL & REFERRAL INFORMATION

Diagnosis:	Is the patient Diabetic? ☐ Yes ☐ No	Do you have a prescription today? ☐ Yes ☐ No
Referral: ☐ Physician ☐ Physical/Occupational Therapist ☐ Specialist ☐ Self ☐ Other:	Family Physician:	Last Visit: (mm/yy)
Referring Doctor & Facility:	Contact Number:	Last Visit: (mm/yy)
Physical/Occupational Therapist & Facility:	Contact Number:	Last Visit: (mm/yy)

INSURANCE INFORMATION

Primary Insurance	Insurance Company:		☐ Private	☐ Medicaid	☐ Medicare	☐ Worker's Comp
	ID#:	Group #:	☐ Other:			
	Subscriber's name:		Subscriber's DOB:		Subscriber's SSN:	
	Relationship to patient:		Employer:			
Secondary Insurance	Insurance Company:		☐ Private	☐ Medicaid	☐ Medicare	☐ Worker's Comp
	ID#:	Group #:	☐ Other:			
	Subscriber's name:		Subscriber's DOB:		Subscriber's SSN:	
	Relationship to patient:		Employer:			
Tertiary Insurance	Insurance Company:		☐ Private	☐ Medicaid	☐ Medicare	☐ Worker's Comp
	ID#:	Group #:	☐ Other:			
	Subscriber's name:		Subscriber's DOB:		Subscriber's SSN:	
	Relationship to patient:		Employer:			

» Assignment of Benefits and Release of Information
I authorize the release of any medical information necessary to process any claims for services or products received through Transcend Orthotics & Prosthetics. I authorize Transcend Orthotics & Prosthetics to be paid all insurance benefits payable for orthotics-prosthetic services and durable medical equipment and supplies rendered to the patient by Transcend Orthotics & Prosthetics. If payment(s) for insurance benefits are made directly to the patient/guarantor, the payee will indorse and remit all checks to Transcend Orthotics & Prosthetics.

» Medicare Assignment of Benefits
I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for covered insurance services to the organization furnishing the services or authorize such organization to submit a claim to Medicare for payment.

» PLEASE READ!
I understand that Transcend Orthotics & Prosthetics is acting solely as an agent for filing insurance benefits assigned to it; however, Transcend Orthotics & Prosthetics assumes no responsibility or guaranteeing payment of covered charges. I understand that I am fully responsible for all deductibles, coinsurance and disallowables. I recognize and affirm my obligation to pay Transcend Orthotics & Prosthetics the total of all charges incurred, and this obligation is in no way dependent upon reimbursement under any medical insurance plan. Any arrangement whereby payments are made directly to Transcend Orthotics & Prosthetics through any insurance plan shall not affect my obligation to pay the remaining balance. I understand that I am responsible for all collections costs, including collection agency fees, attorney fees and court costs associated with collection efforts for any amounts past due to Transcend Orthotics & Prosthetics.

» Return and Adjustments
I have been offered a copy of the Return and Adjustment Policies of Transcend Orthotics & Prosthetics and I understand and agree to these terms and conditions.

» HIPAA Privacy and Medicare Standards
I certify that I have been offered a copy of Transcend Orthotics & Prosthetics Notice of Privacy Practices and Medicare Standards. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information (PHI) that may occur in my treatment, payment of my bills or in the performance of Transcend Orthotics & Prosthetics health care operations. The Notice of Privacy Practices also describes my rights and Transcend Orthotics & Prosthetics duties with respect to my PHI. The Notice of Privacy Practices is posted in the waiting room at Transcend Orthotics & Prosthetics. Transcend Orthotics & Prosthetics reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, asking for one at the time of my next appointment or accessing their website.

» Please Note: For insurance purposes, it Is very important that we have as much information as possible. Incomplete forms can result in the delay of your claim being processed.

I certify that the information for medical insurance is correct. I agree to notify Transcend Orthotics & Prosthetics of any changes in my insurance coverage during the course of the patient's treatment. I certify that I am a patient or duly authorized to act as a patient's agent to execute and accept the above terms and conditions.

I request that payment of authorized insurance benefits be made to Transcend Orthotics & Prosthetics for any items or services furnished to me by that provider. I authorize any holder of medical information about me to any information needed to determine these benefits or the benefits payable for related items or services to release to Transcend Orthotics & Prosthetics.

Printed Name of Patient: ____

Signature of Responsible Party: ______________________________ Date: ______________