PATIENT REGISTRATION FORM

Today's Date:	PCP: How were you referred to us? □ Physician □ Phone Book □ Website □ Friend □ Other: _____		
PATIENT INFORMATION			
Patient's last name: First:		Middle:	Nickname:
Date of birth:	Age:	Sex: □ Male □ Female	Social Security #:
Occupation: □ Full Time □ Part Time □ Full Time Student □ Disability □ Homemaker □ Unemployed □ Retired		Employer:	Employer phone #:
Marital Status: □ Single □ Married □ Divorced □ Widowed □ Other		Home Phone #: □ Primary □ Secondary	Cell Phone #: □ Primary □ Secondary
Email Address:		May we Email you? □ Yes □ No	Text Appt. Reminders? □ Yes □ No
Address:		City, State:	Zip Code:
Billing Address:		City, State:	Zip Code:
Is this a Skilled Nursing Facility? □ Yes □ No		If yes, Name of Facility:	
Have you received a same/similar device? □ Yes □ No		If yes, from whom & when?	
Referring Physician:		Primary Care Physician:	
INSURANCE INFORMATION			
(Please give your insurance card to the receptionist.)			
Name of Primary Insurance:	Subscriber's name:	Subscriber's Date of birth:	Patient's relationship to subscriber:
Policy #:	Group #		
Name of Secondary Insurance:	Subscriber's name:	Subscriber's Date of birth:	Patient's relationship to subscriber:
Policy #:	Group #		
Is this the result of a work- related injury? □ Yes □ No If yes, please provide your claim #:			
Date of Injury:	Employer at time of injury:	Claims Adjustor's Name:	Claims Adjustor's Phone #:
IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

Printed Name: _____ **DOB:** _____

PRIVATE INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE

I authorize payment of medical benefits to Cornerstone Prosthetics and Orthotics for any services furnished to me (or to the patient for whom I am the responsible party) by the Practitioners. I understand that I am financially responsible for any amount not covered by my contract. I authorize you to release to my insurance company information concerning health care, advice, treatment, or supplies provided to me. I understand that I am financially responsible for services provided to me if I am uninsured. **Initial** _____

MEDICARE LIFETIME SIGNATURE ON FILE

I request that payment of authorized Medicare benefits be made on my behalf to Cornerstone Prosthetics and Orthotics for any services provided me by the Practitioners. I authorize any holder of medical information about me to release to the Heath Care Financing Administration and its agents any information needed to determine these benefits or benefits payable for related services. **Initial** _____

FRIENDS AND FAMILY RELEASE

The name(s) listed below are family members or friends to whom I wish to grant access to my health care information. I will rely on the professional judgment of my provider and his/her designee to share such information, as they deem necessary. I understand that information is limited to verbal discussions and that no paper copies of my PHI information will be provided without my signature to release any "sensitive" information. **Initial** _____

The consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. It will be my responsibility to keep this information up to date, as I recognize that relationships and friendships change over time.

Name_____ Relationship: _____ Phone: _____

Name_____ Relationship: _____ Phone: _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I certify that I have received a copy of Cornerstone P&O Notice of Privacy Practices. The notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills, or in the performance of Cornerstone P&O health care Operations. The Notice of Privacy Practices also describes my rights and Cornerstone P&O duties with respect to my protected health information. The Notice of Privacy Practices is posted in the front office. Cornerstone P&O 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 to me in the mail or by asking for one at the time of my next appointment.

Election of Privacy Policy

May we call you at home? □ Yes □ No

May we leave a voice message? □ Yes □ No

Patient Signature: _____ Date: _____