

### **Patient**

Care Crafters Prosthetics & Orthotics, Inc. is here to help restore your mobility.

Our office requires the following:

1) You must have an encounter with your physician and the need for the device **must** be documented in their **notes** (dropfoot, low arches and foot pain, amputation, gait deviations, etc.) also include how you ambulate (assisted, cane, walker, in-home, etc). The doctor must provide a  **cursory prescription:** eval. and fit with [leg brace (AFO), prosthesis, footwear, custom orthotics, etc.].

Attached are three forms for you to complete, please sign and fax or mail (information below) to us along with expanded copies of ID and insurance cards (both front and back).

- 1) Care Crafter's patient information form,
- 2) Patient consent for use and disclosure form,
- 3) Records release form and
- 4) Expanded copies of ID and insurance cards (both front and back).

In the past few years, the number of different health insurance programs has increased at an amazing rate. Even within one company, there may be several programs with varying benefits and requirements. Some programs require pre-authorization, some require referrals, and some may pay a percentage of our charges even in network.

Once we have the completed forms we will call your insurance to understand P&O benefits and then call you to schedule an appointment. At that time we will evaluate you and possibly trial devices or see examples. Please call (845)-426-6900 if there are any questions.

Thanking you in advance

Thaddeus E. Drygas, CPO, FAAOP

*“At care Crafters we personalize the patient experience with dedication and quality craftsmanship”*

**CARE CRAFTERS**  
**PROSTHETICS & ORTHOTICS, INC.**

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**PATIENT REGISTRATION** ID#: \_\_\_\_\_ ( office use only) Initial \_\_\_\_\_

NAME: \_\_\_\_\_ SS#: \_\_\_\_\_  
*(first)* *(last)*

HOME ADDRESS: \_\_\_\_\_  
*(street)* *(city)* *(state)* *(zip)*

CELL PHONE: \_\_\_\_\_ E-MAIL: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SEX: \_\_\_\_\_ MARITAL STATUS: (married) (single) (other)

HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ DIABETIC? \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ PHONE: \_\_\_\_\_

REASON FOR VISIT: \_\_\_\_\_ DATE OF ONSET: \_\_\_\_\_

DO YOU HAVE ANY OTHER HEALTH ISSUES WE NEED TO KNOW ABOUT? \_\_\_\_\_

PRESCRIBING DR: \_\_\_\_\_ PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

PRIMARY DR: \_\_\_\_\_ PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

PHYSICAL THERAPIST: \_\_\_\_\_ PHYSICAL THERAPIST PHONE: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

REFERRED BY: \_\_\_\_\_

**PRIMARY INSURANCE CO:** \_\_\_\_\_

IS THIS AN HMO? PPO? \_\_\_\_\_ IS PRE-AUTHORIZATION NEEDED? \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_ POLICY/CASE/PO# \_\_\_\_\_

INSURED: \_\_\_\_\_ INSURED DOB: \_\_\_\_\_

**SECONDARY INSURANCE CO:** \_\_\_\_\_

IS THIS AN HMO? PPO? \_\_\_\_\_ IS PRE-AUTHORIZATION NEEDED? \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_ POLICY/CASE/PO# \_\_\_\_\_

INSURED: \_\_\_\_\_ INSURED DOB: \_\_\_\_\_

I authorize Care Crafters to release any information acquired in the course of medical examination or treatment for insurance claim filing. I request that all insurance payments be made out to Care Crafters.

SIGNATURE \_\_\_\_\_ DATE: \_\_\_\_\_

**PATIENT CONSENT FOR USE AND DISCLOSURE**  
**OF PROTECTED HEALTH INFORMATION**

I hereby consent to Care Crafters Prosthetics & Orthotics, Inc., using and disclosing my protected health information (PHI) to carry out treatment, payment and healthcare operations (TPO). I hereby acknowledge that I have had the right to review Care Crafters Prosthetics & Orthotics, Inc.'s Privacy Policy prior to signing this consent, which provided me a more complete description of potential uses and disclosures of my PHI. I am aware that Care Crafters Prosthetics & Orthotics, Inc. reserves the right to revise its Privacy Policy at anytime. I am also aware that a revised Privacy Policy may be obtained by my forwarding a written request for same to Care Crafters Prosthetics & Orthotics, Inc.

**Consent to Calls/Mail/Email**

I hereby consent to Care Crafters Prosthetics & Orthotics, Inc. calling my home, cell phone or other designated location and leaving a message on my voicemail or in-person in reference to any items that assist Care Crafters Prosthetics & Orthotics, Inc. in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results and other matters incident to my treatment.

I hereby consent to Care Crafters Prosthetics & Orthotics, Inc. mailing to my home or other designated location any items that assist Care Crafters Prosthetics & Orthotics, Inc. in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

I hereby consent to Care Crafters Prosthetics & Orthotics, Inc. e-mailing me any items or communications that assist Care Crafters Prosthetics & Orthotics, Inc. in carrying out TPO, such as appointment reminder cards and patient statements.

I understand that I have the right to request that Care Crafters Prosthetics & Orthotics, Inc. restrict how it uses or discloses my PHI to carry out TPO. However, Care Crafters Prosthetics & Orthotics, Inc. is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

**By signing this form,** I am consenting to Care Crafters Prosthetics & Orthotics, Inc.'s use and disclosure of my PHI as specified in the Privacy Policy and this Patient Consent for Use and Disclosure of Protected Health Information.

I understand that I may revoke my consent in writing, except to the extent that Care Crafters Prosthetics & Orthotics, Inc. has already made disclosures in reliance upon my prior consent. If I do not sign this consent, I understand that Care Crafters Prosthetics & Orthotics, Inc. may decline to provide treatment to me.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Phone Number(s) (Cell/Home/Work)

\_\_\_\_\_  
Email Address

CARE CRAFTERS  
PROSTHETICS & ORTHOTICS, INC.

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To Whom It May Concern:

Please accept this letter as my authorization to release my medical records to Care Crafters Prosthetics & Orthotics, Inc. located at 95 New Clarkstown Road in Nanuet, New York. Telephone: 845-426-6900 – Fax: 845-426-6926.

Sincerely,

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Birth Date: \_\_\_\_\_

Telephone: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

I understand I have the right to revoke this agreement, in writing, at any time.

\*If signed by a Personal Representative, the following must be included:

Name of Personal Representative: \_\_\_\_\_

\_\_\_\_\_  
Description of Personal Representative's authority to act on behalf of Patient