Excell Orthotics & Prosthetics *Commitment to Excellence*

Patient Information

Cell Phone#:_____ SSN: _____
Email Address:_____ Date of Birth: _____

Mr. □ Mrs. □ Miss □: _____ _____ _____
Last Name First Name M.I.
Address: _____City: _____
State: _____ Zip: _____ Home Phone #: (_____)_____
Marital Status: Married □ Single □ Divorced □ Minor □ Widowed □
Employer:_____ **Or Retirement Date**: _____/____/_____
Employer's Address (Street, City, State, Zip) _____
Employer's Phone#: (_____)_____

In Case of Emergency Contact: Name: _____ Phone #: (_____)_____
Address (Street, City, State, Zip): _____

Referring Physician: _____ Phone #:_____
Primary Care Physician: _____ Phone #:_____

Is Condition Related to Employment or Accident? Yes □ No □ Date of Injury:_____ Claim#_____
Adjuster's Name _____Adjuster's Phone # (_____)_____

How do you intend to pay for your portion? Cash □ Check □ Debit/Credit Card □

Policy Holder Information; Complete ONLY if information is different than above

Name:_____ Date of Birth:_____ Phone #:_____
Address:_____ City, State, Zip:_____
Employer:_____ Work Phone:_____
Address:_____ City, State, Zip:_____

Have you switched your Medicare Coverage to an Advantage, HMO or Replacement Policy? Yes □ No □

Primary Insurance:_____
Policy # - Group Name/Number:_____
Secondary Insurance:_____
Policy # - Group Name/Number:_____

ASSIGNED BENEFITS / AUTHORITY FOR RELEASE OF INFORMATION

I request that payment of authorized Medicare, Medicaid or private insurance benefits be made directly to Excell Orthotics & Prosthetics, for any covered services furnished to me by Excell Orthotics & Prosthetics. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents, Champus and its agents or to any private insurance company any information needed to determine those benefits or the benefits payable for related services. If this is a private insurance claim, I further agree to be responsible for the full amount of the charges from the date of delivery if my private insurance company does not pay for the charges in a timely manner, or if my physician or I fail to provide within thirty (30) days the information necessary to submit the claim for payment.

X_____ _____
Patient Signature (or Parent/Guardian) Date

X_____ _____
Representative/POA (If Patient is unable to sign) Relation to Patient