# 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 the physician's **notes** (drop foot, low arches and foot pain, amputation, gait deviations, etc.) the notes must also include how you ambulate (assisted, cane, walker, in-home, etc). The doctor must provide a **cursory prescription:** evalulate 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 Crafters 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 only a percentage of our charges even in network.

Once we have the completed forms we will call your insurance to understand the prosthetic and orthotic benefits of your plan and then call you to schedule an appointment. At that time, we will evaluate your patient and provide examples of devices and/or trial devices for them. 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.

***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:_____________________ PHONE:_________________FAX:______________

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:__________________

95 NEW CLARKSTOWN ROAD. NANUET, NEW YORK 10954-5203

TEL: 845-426-6900 . FAX: 845-426-6926 . WEBSITE: www.carecrafters.com

*Updated June 2017*

# 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

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