Park Avenue Orthotics, Inc.

155 East 55th Street, Suite 200, New York, NY 10022 (TEL) 212.297.0362 (FAX) 212.697.3697

Patient Diagnosis / ICD Code _____ **Date of Injury** ____ / ____ / ____ (Required for WC/Auto Injury)

Left _____ **Right** _____ **(Required For Billing)**

Prescription
(Affix Brace Label Here)

Doctor's Signature _____ **Date** _____ / _____ / _____
(Original Required by Medicare)

PATIENT INFORMATION (MUST BE COMPLETED)	**INSURANCE INFORMATION (COMPLETE OR ATTACH)**
Name _____	Insurance Carrier _____
Address _____Apt_____	Policy/ID # _____
City _____ State _____ Zip _____	Secondary _____
Phone _____	**ATTENTION MEDICARE BENEFICIARIES:**
DOB _____ / _____ / _____ Sex M_____ F_____	**Please Sign the Two Attached Forms Required by Medicare.**

CLINICIAN NOTES:

DELIVERY RECEIPT AND AUTHORIZATION TO RELEASE INFORMATION AND PERMIT PAYMENT OF INSURANCE BENEFITS TO PROVIDER, PARK AVENUE ORTHOTICS, INC.

I authorize my physician to release to Park Avenue Orthotics, Inc. and for Park Avenue Orthotics, Inc. to release to my insurance carrier any needed information for this or a related claim. I request that payment of authorized benefits be made on my behalf, and I assign the benefits payable for the medical equipment provided by Park Avenue Orthotics, Inc. to Park Avenue Orthotics, Inc. Although I recognize that I have primary responsibility for contacting and submitting claims to my insurance carrier, I have received the equipment and authorize Park Avenue Orthotics, Inc. to submit a claim to my insurance carrier. I understand that I am responsible for any unpaid balances, including deductibles and co-insurance. Should my insurance carrier not provide coverage:
I understand that I am responsible for payment. I have read, understand, and agree to the above.

PATIENT/AUTHORIZED SIGNATURE _____ **DATE**_____

Notice of Privacy Practices and Patient Rights: Please call our office at 212.297.0362 for more information about Park Avenue Orthotics, Inc. Privacy Practices, Patient Bill of Rights and Insurance Participation.

Card Number _____ **Amount** $_____

Card Holder's Signature _____ **Exp. Date**_____ **CVC Code**_____

Billing Zip _____

THIS MEDICAL EQUIPMENT IS FOR SINGLE-PATIENT USE ONLY AND CANNOT BE RETURNED. DEFECTIVE ITEMS WILL BE EXCHANGED.