STUDIO I

Patient Information				
Patient's Last Name: First: Middle:			Nickname:	
Street Address:		City:	State:	Zip Code:
Marital Status: □ Single □ Married □ Divorced □ Widowed			Date of Birth: / /	
Social Security Number:	Home Phone:	Mobile Phone:	Email:	
Occupation:	Employer:		Phone:	
Emergency Contact:	Phone:		Relationship:	

Spouse's Information			
Spouse's Last Name: First: Middle:		Date of Birth:	Social Security Number:
Employer:		Employer's Phone:	

Physician Information		
Primary Physcian:	Phone:	Location:
Oncologist:	Phone:	Location:
Radiologist:	Phone:	Location:
Surgeon:	Phone:	Location:

Primary Insurance Information		
Insurance Company:	Insurance ID #:	Group #:
Policy Holder:	Relationship to Patient:	

Secondary Insurance Information		
Insurance Company:	Insurance ID #:	Group #:
Policy Holder:	Relationship to Patient:	

Additional Insurance Information		
Insurance Company:	Insurance ID #:	Group #:
Policy Holder:	Relationship to Patient:	

Policyholder Information			
If patient is not the policyholder or spouse, this section must be filled out.			
Last Name: First: Middle:	Same Address as Patient □ Y □ No		Date of Birth:
Street Address:	City & State:	Zip Code:	Social Security Number:

Release of Protected Health Information To Others			
I give my consent and authorization for the medical or billing staff of Studio I to release **Protected Health Care Information** about me or for me to the people that I have listed below.			
First Name:	Last Name:	Relationship:	Phone:
1			
2			

Reason for Visit

STUDIO I

Medical Diagnosis		Product/Service	
□ Breast Cancer	□ _________________ Cancer	□ post surgical garment	□ post mastectomy bra
□ Alopecia	□ Lymphedema	□ breast prosthesis	□ bra fitting
□ Non-Medical	□ Other __________________	□ compression garment	□ cranial prosthesis (wig)

Notice of Privacy Practices

Pursuant to the Health Insurance Portability and Accountability Act of 1996, I acknowledge that I have received a copy of **NOTICE OF PRIVACY PRACTICES.**

INITIAL___________

Release of Medical Information and Authorization to Pay Insurance Benefits

I request payment of authorized Medicare and/or private insurance benefits to be made either to me or on my behalf to Studio I for any products furnished me by that provider. I authorize any holder of medical information about me to release to the health care financing administration and its agents and information needed to determine these benefits payable for related products.

INITIAL___________

Financial Agreement

I understand all accouts are the full responsibility of the patient and /or the patient's responsible party. Studio I will assist in obtaining insurance benefits on your behalf. However, if there is an outstanding balance on the patient's account, they will be responsible for payment of that balance.

INITIAL___________

Supplier Standards

The products and/ or services provided to you by Studio I are subject to the supplier standards contained in the federal regulations shown at 42 Code of Federal Regulations Section 424.57©. These standards concern business professional and opperational matters. The standards can be obtained at ecfr.gpoaccess.gov. Upon request we will furnish you with a written copy of the standards.

INITIAL___________

_____ I am currently enrolled in Hospice

INITIAL___________ _____ I am NOT currently enrolled in Hospice

Signature Verification

By signing below I verify that all information is valid and true to the best of my knowledge.

Patient Signature____ Date____________________________

I verify that all **previous information is still valid and true** to the best of my knowledge.

Patient Signature____ Date____________________________

Patient Signature____ Date____________________________

Patient Signature____ Date____________________________