Central Ohio Orthotic & Prosthetic Center

Improving Human Capability in Central Ohio

Patient Registration Form

Patient Information: Use this form - if patient is AGE 18 or OLDER

First Name:		Middle Initial:		Last:		☐ Male	☐ Female
Street Address:		City:		State:		Zip:	
Date of Birth:		SSN:		Height		Weight:		Shoe Size:	
Cell #:		Email:		☐ Single ☐ Widow	☐ Married ☐ Divorced
Employer:		Work Phone:		☐ Diabetic	☐ Allergy to Latex
Referring Dr.:		Primary Care Dr.:		Physical Therapist:	
Do You Have An Orthotic or Prosthetic Device?	☐ Yes ☐ No	If Yes – What Year Received?		Company Who Provided Device:	
How Did You Hear About Us:	☐ Doctor:		☐ Hospital:		☐ Family or Friend:		☐ Other:	

Emergency Contact:

Name:		Relationship to you:	☐ Spouse ☐ Parent ☐ Friend ☐ Neighbor ☐ Other ________
Cell #:		Email:		Can We Release HIPAA Info?	☐ Yes ☐ No

Insurance Information:

Medical Card: Medical Card is: ☐ Primary Insurance ☐ Tertiary Insurance ☐ Secondary Insurance ☐ ONLY Insurance

☐ BCMH ☐ Buckeye Health ☐ CareSource ☐ Medicaid ☐ Molina ☐ Paramount ☐ Other ________

Recipient Name:		ID No:		Date of Eligibility:	
Type of Primary Ins:		ID No:		Group No:	
Name of Policy Holder:		Policy Holder Employer:	
Policy Holder Social Sec #:		Policy Holder Date of Birth:		Relationship to Patient:	☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Other: ________
Policy Holder Address:		City:		State:		Zip:	
Cell #:		Email:	
Type of Secondary Ins:		ID No:		Group No:	
Name of Policy Holder:		Policy Holder Employer:	
Policy Holder Social Sec #:		Policy Holder Date of Birth:		Relationship to Patient:	☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Other: ________
Policy Holder Address:		City:		State:		Zip:	
Cell #:		Email:	
BWC Case Manager:		Case Manager No.:	
Claim No.:		Date Of Injury:		Employer At Time Of Injury:	
Managing Physician:		Managing Dr.'s Contact No.:	

Please give the receptionist your Driver's License, Insurance Card(s), Prescription and/or X-Rays.

By signing below:
I certify that the information provided by me is true, accurate and complete.

Signature of Patient or Responsible Party:		Date:	

© 2018 - Central Ohio Orthotic & Prosthetic Center, Inc.

Central Ohio Orthotic & Prosthetic Center

Improving Human Capability in Central Ohio

Patient Registration Signatures

For Patient:		Date of Birth:		☐ Male	☐ Female

Acknowledgement of Privacy Practices:

I acknowledge that I have been offered a copy of Central Ohio Orthotic & Prosthetic Center's Notice of Privacy Practices. I understand the Notice describes the types of uses that might occur with my protected health information during my treatment and/or insurance billing or within the performance of the company's health care operations. I understand it also describes my rights and the company's duties with respect to my protected health information. I acknowledge that Central Ohio Orthotic & Prosthetic Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices and are also posted in the front office. I understand I may obtain a revised Notice of Privacy Practices by visiting, calling, emailing or writing the office.

Signature of Patient or Responsible Party:		Date:	

Acknowledgement of Medicare Supply Standards:

I acknowledge that I have been given a copy of the Medicare Supply Standards. I have read over them and agree with them. I understand that if I have any questions, the staff at Central Ohio Orthotic & Prosthetic Center will answer them for me.

Signature of Patient or Responsible Party:		Date:	

Acknowledgement of Insurance Waiver:

I acknowledge that as a courtesy, Central Ohio Orthotic & Prosthetic Center will verify insurance benefits for services being performed. I understand that a benefit quoted by my insurance does not mean a guarantee of payment and that I am financially responsible for all charges whether or not covered by my insurance. I am aware that my insurance company may require a pre-certification, prior-authorization or a pre-determination. I acknowledge those requirements can take up to 3 or 4 weeks before my device will be ready for delivery. I understand that any service billed to my insurance company that is not a covered service, will be my responsibility to pay in full. I understand that I am responsible for providing up-to-date and accurate insurance information at every appointment. I acknowledge that I will be responsible for any amounts not paid by insurance if I fail to provide appropriate insurance information for billing. I understand that I will be responsible for any collection fees that may be added to my account for non-payment.

Signature of Patient or Responsible Party:		Date:	

Authorization to Release My Protected Health Information:

I authorize the release of medical records about me, by any holder of medical information, to Central Ohio Orthotic & Prosthetic Center. I understand these records will be used by COOPC to determine medical necessity with an insurance company, obtain authorization with an insurance company, in the event of billing an insurance company and obtaining physician notes and/or prescriptions. Release medical records to Central Ohio Orthotic & Prosthetic Center. Their contact information is: 3059 E. Mound St., Columbus, OH 43209. Phone - (614) 231-4256. Fax – (614) 231-0127. Email - 231HALO@COOPC.org.

Signature of Patient or Responsible Party:		Date:	

Authorization of Payment to Central Ohio Orthotic & Prosthetic Center:

I authorize payment of my private insurance benefits, Medicare benefits and/or Medicaid benefits be made directly to Central Ohio Orthotic & Prosthetic Center for any covered services, furnished by COOPC. I request that payment of authorized benefits be made on my behalf. I assign benefits payable for covered private insurance, Medicare and/or Medicaid services to Central Ohio Orthotic & Prosthetic Center. I authorize COOPC to submit a claim to my private insurance, Medicare and/or Medicaid for payment on services they have provided to me. I agree to pay to Central Ohio Orthotic & Prosthetic Center any deductible, co-payment, co-insurance on my claim.

Signature of Patient or Responsible Party:		Date:	

Authorization to Contact Me:

I authorize Central Ohio Orthotic & Prosthetic Center to contact me regarding my care and/or the care of the above named patient. Contact by phone or email regarding appointments, treatment instructions, prescriptions, x-rays, physician notes, insurance authorizations, insurance payments and/or denials and/or billing information.

Signature of Patient or Responsible Party:		Date:	

Authorization to Use Photo, X-rays, 3D Scans or Video Recordings:

I authorize the use of photographs, x-rays, 3D scans, video and/or voice recordings of me or my child by COOPC. I understand the material may become part of my or my child's medical record and used as documentation of care. COOPC may use the above mentioned materials any manner that the company deems appropriate in order to obtain authorization, pre-certification, pre-determination or make appeals on my behalf to my insurance carrier of record. They may also use the materials to share with my physician in order to obtain a new prescription on my behalf. The material may be used for educational purposes to physicians, hospitals, other healthcare providers and for training COOPC staff. It may appear in recruiting materials that COOPC participates in. Authorization is continuous, but may be withdrawn by my specific request.

Signature of Patient or Responsible Party:		Date:	

© 2018 - Central Ohio Orthotic & Prosthetic Center, Inc.

Central Ohio Orthotic & Prosthetic Center

Improving Human Capability in Central Ohio

Patient Medical History Form

To better understand your particular orthotic and/or prosthetic needs, Central Ohio Orthotic & Prosthetic Center would appreciate it if you could answer the following questions. **Please keep in mind that your insurance company may also need this information in order to consider coverage of your device.**

Patient Name::		Date of Birth:		☐ Male	☐ Female

In the last 3 weeks:

Have you or anyone in your household had any of the following:

☐ **Cold** ☐ **Cough**

☐ **Fever** ☐ **Flu**

In the last 3 months:

Have you or anyone in your household been out of the Country? ☐ **No** ☐ **Yes**

If Yes, List Locations That Were Traveled:

____

____

What areas do you need examined:

☐ Ankle ☐ Back ☐ Chest ☐ Elbow ☐ Foot

☐ Hand ☐ Hip ☐ Knee ☐ Leg ☐ Neck

☐ Shoulder ☐ Wrist

A specific side? ☐ Left ☐ Right ☐ N/A

Have you previously been evaluated or fit with the type of device we are going to see you for? ☐ No ☐ Yes

If yes, where & when did you receive the device? ______________

____

Describe your experience with the device: ______________

____

Please describe how you came to need an orthotic / prosthetic brace:

Please indicate if you have any of the following:

☐ Amputation: ☐ Leg ☐ Arm	☐ Cerebral Palsy	☐ Leg Length Discrepancy	☐ Scoliosis
☐ Arterial Sclerosis	☐ Circulatory Problems	☐ Nerve Damage	☐ Stroke
☐ Arthritis	☐ Cerebral Palsy	☐ Numbness	☐ Swelling of Limbs (Edema)
☐ Asthma	☐ Diabetes	☐ Open Sores	☐ Tendon or Ligament Tear
☐ Autism	☐ Flat Feet	☐ Osteomyelitis	☐ Trauma
☐ Back Pain	☐ Gout	☐ Osteoarthritis	☐ Tumor
☐ Bleeding Disorders	☐ Heart Disease	☐ Phantom Pain (Limb not there)	☐ Ulcerations
☐ Blood Disease	☐ Hemi Paresis	☐ Pigeon Chest	☐ Varicose Veins
☐ Bruise Easily	☐ Kidney Disease	☐ Polio	☐ Other; please list below:
☐ Cancer	☐ Kyphosis	☐ Pulmonary Disease	

Please list any known allergies:	Does patient's weight fluctuate: ☐ No ☐ Yes / Explain below:	Is patient able to dress themselves? ☐ No ☐ Yes	Does the patient use any of the following? ☐ Wheelchair ☐ Cane ☐ Walker ☐ Crutches

What type of leisure activities does the patient participate in:

Recent hospitalizations? ☐ No ☐ Yes / Explain below:

____

____

© 2018 - Central Ohio Orthotic & Prosthetic Center, Inc.