MORGANTOWN ORTHOTIC & PROSTHETIC CENTER

TODAY'S DATE ___________________________ Patient ID _______________

Last Name: ________________________ First: _______________________Middle:__________________

Nickname: __________________ DOB: _____________ Gender: M F SSN#_____________________

DL #: ___________________ Marital Status:_____________ Language: ______________

Home Phone: ___________________________ Cell Phone: _________________________________

Address: ____

City: _______________________________ State: ______ Zip: _________________

Vocation:____________________________ Employer Name:___________________________________

Email Address: ____

___ American Indian or Alaskan Native

___ Native Hawaiian or Other Pacific Islander

___ Asian

___ White

___ Black or African American

___ Other: ______________________________

___ Prefer not to answer

PLEASE CIRCLE ANSWERS

- **Hispanic/Latin**: YES NO Prefer not to answer
- **Education**: Some High School High School/GED Some College/Tech
  College Degree Graduate Degree Prefer not to answer
- **Armed Forces**:
  Active Reserves Veteran Not a member Prefer not to answer
- **Emergency Contact**
  Name: _________________________________ Relationship: ____________________
  Home Number: ___________________________ Cell: ___________________________
  Address: ____

Outside of the normal HIPPA standards there may be times you want us to/not to give information to family and friends about your care with us.

Information can be given to: ____

Information can NOT be given to: ____

INSURANCE INFORMATION

Primary Insurance:

Carrier Name: _________________________________

Policy Holder: ____________________________________

Relationship to patient: ___________________________

Policy Holder Date of Birth: ________________________

Policy Holder SSN#: _____________________________

Insurance ID #:___________________________________

Group #:____

Secondary Insurance:

Carrier Name: ____________________________________

Policy Holder: ___________________________________

Relationship to patient: ____________________________

Policy Holder of Birth:__________________________________

Policy Holder SSN#:__________________________________

Insurance ID #:____

Group #:____

Third Insurance:

Carrier Name: _______________________________________

Policy Holder: _______________________________________

Relationship to patient: _______________________________

Policy Holder Date of Birth: ____________________________

Policy Holder SSN#:__________________________________

Insurance ID #:_______________________________________

Group #:____

Workers Comp

WC Company: ____________________________________ Date Of Injury: ______________ State of Injury: ______________

Case Manager Name: ____ Case Manager Phone Number: _____________________

Claim#: ________________________________ Employer: ____

Covered Diagnosis: ___________________________________ Physician: ____

Financial Arrangements after Insurance

For your convenience, we offer the following methods of payment. Please check the option which you prefer.

______ Cash ______ Personal Check _____ Credit Card (Visa MC Discover AM)

______ I wish to discuss payment arrangements

PATIENTS WHO FAIL TO COME TO THEIR SCHEDULED APPOINTMENT MAY BE CHARGED $50.00. THIS WILL BE BILLED TO THE PATIENT, NOT THE INSURANCE COMPANY.

Authorization and Release

I authorize the release of any information including the diagnosis and the records of any treatment or examination to me or my child during the period of such care to third party payers and/or other health practitioners. I also understand that my photograph and video maybe used for insurance submission and educational purposes. Other reasons will require another release form.

I authorize and request my insurance company to pay directly to Morgantown O&P Center insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient's Signature_______________________________________Date:_______________

MEDICAL PROFILE

Height: ____ft _____in **Weight:** ______ lbs

Referring Physician (That sent you to us): ____ Phone#__________________

Primary Care Physician:____ Phone# _____________________________________

Does your PCP treat your Diabetes? Yes NO

If No who treats your Diabetes: _____________________________________ Phone#___________________________

Circle all that apply

- **Tobacco Use:** Currently Used but quit Never Used Prefer not to answer
- **Falls in the last 6 months:** Yes No If yes, how many ________
- **Hospital, ER, or Urgent Care visits in the Last 6 months:** Yes No
    - If yes, explain ____
    - Is this related to a fall: Yes No
    - If yes explain: ____
- **General Health:** Poor Fair Good Excellent
- **Activity Level:** Sedentary Limited Active Very Active
- **Accident from Employment**: Yes No
    - If yes Date: __________ State: __________ Country: _________
    - Description ____
- **Auto Accident:** Yes No
    - If yes Date: __________ State: ___________ Country: ___________
    - Description ____
- **Other Accident:** Yes No
    - If yes Date: __________ State: _____________ Country: _______________
    - Description ____
- **Received Device within the Past 5 Years:** Yes No
    - If yes what device____
    - When was device received____
- **Allergies:** Yes No If yes explain ____
- **Current Medications:**

____

____

Please list any major surgeries:

1. ____ Year_____________
2. ____ Year_____________
3. ____ Year_____________
4. ____ Year_____________

MEDICAL CONDITIONS

___Alzheimer's or Dementia
___Anxiety
___Asthma
___Pulmonary Disease (TB)
___Intestinal Problems
___Kidney Disease
___Diabetes Type I
___Diabetes Type II
___Neurological Problems
___Obesity
___ Osteoarthritis

___High Blood Pressure
___HIV
___Infections
___Brain Injury/TBI
___Rheumatoid Arthritis
___Seizure Disorders
___Migraines
___Stroke/TIA/CVA
___Vascular Disease
___Vision Problems

___Osteoporosis
___ Parkinson's
___ Cancer
___Depression
___Liver Disease
___Skin Problems
___MRSA
___Hearing Loss
___Heart Problems
___Hepatitis

Other Conditions:

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Acknowledgement of Receipt of Notice of Privacy Practices

I certify that I have received a copy of **Morgantown O & P Center's** Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of protected health information that might occur in my treatment, care operations. The Notice of Privacy Practices also describes my rights and **Morgantown O & P Center's** duties with respect to my protected health information. The Notice of Privacy Practices is posted in the reception area.

Morgantown O & P Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practice. I may obtain a revised Notice of Privacy Practice by calling the office and requesting a revised copy to be sent in the mail, and asking for one at the time of my next appointment.

____
Signature of Patient or Personal Representative

____ __________________________
Print Name of Patient or Personal Representative Relationship to Patient

____
Date

Acknowledgement of Receipt of Medicare DMEPOS Supplier Standards

I certify that I have received a copy of **Morgantown O & P** Center's Medicare DMEPOS Supplier standards. The Medicare DMEPOS Supplier Standards is a list of standards that all Medicare DMEPOS Suppliers must meet in order to obtain and retain their billing privileges.

____
Signature of Patient or Personal Representative

____ __________________________
Print Name of Patient or Personal Representative Relationship to Patient

____
Date