Patient Registration Form

Patient Name:______________________ Middle:____________ ____________________________
(Last) (First)

Street Address:____

City: ______________________________ State: _____________________ Zip Code: __________________

Alternate Address: ____

____

Cell Number: ___________________________ Home Number: __________________________________

Sex:____ Date of Birth: __________ Age: ____ Email: ____

Subscriber's Insurance Information, IF different from Above:

Name:_______________________________ DOB:________________ Contact: ______________________

Are you currently residing in a skilled nursing facility? Yes ☐ No ☐ (check one)

If Yes, Name of facility: ____

Name of Emergency Contact: ______________________________ Relationship:_______________________

Phone Number: _____________________________

Assignments of Benefits/Financial Agreement

I hereby give authorization for payment of insurance benefits to be made directly to Applied Orthotics & Prosthetics, for services rendered. I **understand that authorization is not a guarantee of payment and that I am financially responsible for all charges.** In the event authorization has not been obtained by the patient or referring physician, the patient is liable to all charges. If the patient is a minor, the guarantor will be responsible. After **90 days** a service charge, based on hourly rate and materials, will be made for any repairs. I further authorize the release of any medical information necessary in regards to my condition and status of account. A photocopy of this agreement shall be valid as the original. **I also understand that all purchases are non-refundable.**

Signature: ____ Date: _____________________________

***** we accept Visa & MasterCard Only

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