Paul L. Valentine Orthotics and Prosthetics, LLC
PATIENT INFORMATION

Thank you for selecting Paul L. Valentine Orthotics and Prosthetics. In order to serve you properly, we need the following information. All information will be kept confidential, according to HIPPA regulations.

Patient Name ______ Gender ______ Today's Date ______

Address ______ City ______ State ______ Zip Code ______

Home Phone ______ Work or Cell Phone ______ Date of Birth ______

Patients SS# ______ Referring Physician ______ Phone # ______

Parent,guardian,or spouse's name ______ Date of Birth ______ Relationship to patient ______

Which body part are we treating, please be specific ______

Reason for treatment (diagnosis) ______ Date of injury or amputation,if applicable ______

INSURANCE INFORMATION

As a courtesy, we call your insurance company to check the benefits for the orthotic equipment prescribed for you. Any benefit information quoted to you is based on the information obtained from the insurance company and is not a guarantee of your benefits or payment. We will assist in obtaining an authorization for the equipment when required and will not release merchandise until the authorization is complete and all co-insurance and deductible are paid in full.

Is this a worker's compensation claim? ______ If yes, please request the appropriate form.

Insurance Company ______ Identification Number ______

Name of Insured ______ Relationship to patient ______

Date of Birth ______ Employer ______

If different than above:

Address ______ City ______ State ______ Zip Code ______

Home Phone ______ Work Phone ______ Cell Phone ______

Do you have any additional insurance? ______ If yes, please complete the following:

Secondary Insurance Company ______ Identification Number ______

Name of Insured ______ Date of Birth ______ Relationship to patient ______

Address ______ City ______ State ______ Zip Code ______

I authorize the release of health information concerning my, or my child's health care, advice and or treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize my insurance company to pay directly to Paul Valentine O & P, insurance benefits otherwise payable to me. I understand 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 behalf. Please contact us if an item you have received does not fit properly. **No returns will be accepted after three (3) business days.** I agree to pay all costs incurred in the collection process, including court cost and attorney fees.

______________________________ Current Date ______

Signed By