**GREAT LAKES ORTHOPEDIC LABS, INC.**
1031 Main Street, Buffalo, NY 14203
Tel No. (716) 893-4116

# PATIENT INFORMATION

Patient's Name _____ Sex – M ☐ F ☐

Patient's Social Security No._____ Date of Birth _____

Patient's Street Address _____

City, State and Zip Code _____ County _____

Home Telephone No. _____ Cell Phone No. _____

Diagnosis _____ Prescribing Doctor _____

Height _____ Weight _____ Physical Therapist _____

## RESPONSIBLE PARTIES

Father or Guardian _____

Date of Birth _____ Social Security No. _____

Address: _____

Telephone Nos. Home_____ Cell _____ Work _____

Employer and Address_____

Mother or Guardian _____

Date of Birth _____ Social Security No. _____

Address: _____

Telephone Nos. Home_____ Cell _____ Work _____

Employer and Address_____

## INSURANCE INFORMATION

**PRIMARY INSURANCE (**Include Subscriber's Name, Identification No. and Group No.)

_____

_____

**SECONDARY INSURANCE** (Include Subscriber's Name, Identification No. and Group No.)

_____

**IF MEDICAID –** Identification # _____Sequence # _____
(Two digit number located at lower right hand corner of card)

**(OVER)**

## ADDITIONAL FUNDING AVAILABLE

**EARLY INTERVENTION PROGRAM** (For children age 3 years or younger)

Is your child enrolled in the Early Intervention Program? Yes _____ No _____

* * *

**ASSIGNMENT OF BENEFITS** - I hereby authorize the insurance companies listed above to make payment of benefits directly to Great Lakes Orthopedic Labs, for services rendered by them. I also authorize the release of any medical information by Great Lakes to process any claims.

**FINANCIAL AGREEMENT** - I hereby agree that in consideration of the services rendered, I shall pay the account of Great Lakes Orthopedic Labs in accordance with their charges for services rendered. I also understand that for any unpaid balance after 30 days, a charge of 1.5% monthly will be assessed on the account. I also agree that if the account becomes delinquent and thereby requires the services of an attorney for collection, I shall pay reasonable collection expenses and attorney's fees.

**PRIMARY CONTACT INFORMATION:**

**PHONE NUMBER: _____**

**EMAIL ADDRESS: _____**

*******Your email address will be used only for purposes pertaining to your care***

_____ _____

**Patient's Signature or Authorized Representative** **Date**

# Consent for the Use and Disclosure of Protected Health Information

By signing below, you consent to the use and disclosure of your protected health information by GREAT LAKES ORTHOPEDIC LABS, INC., our staff, and our business associates for treatment, payment and health care operations purposes. For a more detailed description of our uses and disclosures of protected health information, please review our Notice of Privacy Practices ("Notice"), which you acknowledge being informed of and have declined to take a copy of on this date. You have the right to review our Notice prior to signing this consent.

The terms of this Notice may change. If the terms do change, you may obtain a revised Notice by simply contacting us at (716) 893-4116 and requesting a revised Notice. You have the right to request that we restrict our uses or disclosures of your protected health information that we are otherwise permitted to make for treatment, payment and health care operations, although we are not required to agree to these restrictions. However, if we agree to further restrictions, they are binding on us. Finally, you have the right to revoke the consent in writing, except to the extent that we have taken action in reliance on it.

By signing below, I acknowledge being aware of GREAT LAKES ORTHOPEDIC LABS, INC. posted Notice of Privacy Practices, dated April 1, 2003. I have **declined to accept a copy** of such Notice but understand that I may request a copy by calling Great Lakes Orthopedic Labs, Inc. at (716) 893-4116.

Patient's Name _____ Date of Birth _____

_____ _____

Signature of Patient or Personal Representative* Date

* IF SIGNED BY A PERSONAL REPRESENTATIVE, THE FOLLOWING INFORMATION MUST ALSO BE INCLUDED

_____

Printed Name of Personal Representative

_____

Description of the Personal Representative's authority to act on behalf of the patient

Signature on Consent could not be obtained because:

_____ Individual refused to sign Consent

_____ Communications barriers prohibited obtaining the signature.

Other (Specify): _____

Great Lakes Orthopedic Labs
Orthotics and Prosthetics

1031 Main Street
Buffalo NY 14203-1014
P: (716) 893-4116
Fax: (716) 897-2110

# Practice Policies

The staff at Great Lakes Orthopedic Labs feels that we can better serve your needs if you are familiar with the following policies and procedures:

**Insurance Information/Assignment of Benefits**
Patients are required to provide Great Lakes Orthopedic Labs with current and accurate insurance information at every visit. Failure to provide accurate information will result in a patient bill that you may be held responsible for. By signing below, you authorize Great Lakes Orthopedic Labs to share information to insurance carriers concerning our services and hereby assign all payments for services rendered to you or to your dependent to Great Lakes Orthopedic Labs. Furthermore, you will be held responsible for any amount not covered by your insurance plan.

**Financial Agreement**
I hereby agree that in consideration of the services rendered, I shall pay the account of Great Lakes Orthopedic Labs in accordance with their charges for services rendered. I also understand that for any unpaid balance after 30 days, a charge of 1.5% monthly will be assessed on the account. I also agree that if the account becomes delinquent and thereby requires the services of an attorney for collection, I shall pay reasonable collection expenses and attorney's fees.

**Co Insurance, Insurance Deductibles, POS Plans, Private Payments and Custodial Parent Responsibility**
In accordance with the provision of your insurance plan, you may be required to pay for a portion or all of your services. As a result, if you have a deductible and/or co-insurance with your insurance plan, a Point of Service Plan, or if you are a private paying patient, payment is expected at the time of service.

The custodial parent is responsible for payment at the time of service whether the account is considered self-pay, participating insurances, or nonparticipating insurance. The office does not get involved with divorce specifics, e.g., one parent pays 80% and the other pays 20%. It is the parents' obligation to work out an agreement themselves or through the court system. For patients who present without an applicable payment due, your appointment will be rescheduled.

Great Lakes Orthopedic Labs makes every attempt to provide its patients with accurate co-insurance and deductible patient responsibility information at the time of service. However, due to the nature of our practice, additional liability may be due when components of an orthosis need to be changed and/or when information originally obtained from insurance representatives differs once the claim has processed. If Great Lakes Orthopedic Labs determines that a claim has been incorrectly processed by the insurance company, we will vigorously pursue a reprocessing of the claim. Any additional amounts due will be billed accordingly. Any overpayments will be refunded once the claim has processed. Please note that it is within our discretion to take current payments and apply them to existing unpaid balances.

**Medical Photography**
Any photography taken for treatment purposes will become a part of your patient record. These photos shall remain confidential in accordance with regulatory requirements.

**Comments**
Should you need to discuss this policy or your payment, you may contact our office prior to your appointment, so appropriate arrangements can be made. It is our sincerest desire that you will have no occasion to register a concern. However, should that occasion arise, please call Blanche Daley at (716)893-4116. To ensure a good office policy, please fill out a patient survey. Your feedback is encouraged at all times to assist us in improving service to our patients.

*I have read the Practice Policies listed above and hereby agree to each policy.*

**Name (Please Print): _____**

**Signature: _____ Date: _____**