VIRGINIA PROSTHETICS & ORTHOTICS PATIENT INFORMATION FORM

PATIENT INFORMATION

Last Name	First Name		Middle Initial	Nickname
Date of Birth	Gender (check one) ☐ Male ☐ Female	SSN	Email Address	
Home Address	City	ST	Zip Code	Primary Language
Marital Status	Home Phone		Cell Phone	

How did you hear about us?
☐ Doctor/Hospital: Doctor Name ________________ Hospital Name ______________ ☐ Patient ☐ Friend/Family ☐ Internet Search

GUARANTOR INFORMATION (check one) ☐ Self ☐ Spouse ☐ Parent ☐ Employer ☐ Other ____________________

Guarantor Name	Address	Phone Number
Email Address	Date of Birth	Relationship to Patient

EMERGENCY CONTACT

Name	Relationship to Patient	Phone Number

PLEASE LIST OTHER INDIVIDUALS WHO WE CAN COMMUNICATE WITH REGARDING APPOINTMENTS AND MEDICAL INFO.

Name (First, Last)	Relationship to Patient	Phone Number
1.		
2.		

INSURANCE INFORMATION *(PLEASE PROVIDE YOUR INSURANCE CARD TO THE PATIENT CARE COORDINATOR)

Please Check Box if SELF Pay ☐		Worker's Comp Case ☐ Yes ☐ No		
1. Company Name	☐ Primary ☐ Secondary	ID#		
Subscriber Name	Relationship to Patient	Phone Number	DOB	SSN
2. Company Name	☐ Primary ☐ Secondary	ID#		
Subscriber Name	Relationship to Patient	Phone Number	DOB	SSN

PLEASE SEE REVERSE SIDE

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PATIENT THERAPY INFORMATION

☐ Yes ☐ No | Are you currently or have you recently worked with a physical and/or occupational therapist?

If yes, please answer the following:

☐ Physical Therapist ☐ Occupational Therapist

Name of Therapist ______________________ How often?____________

ADDITIONAL INFORMATION

☐ Yes ☐ No | Have you received a like or similar device within the last 2–3 years from either Virginia Prosthetics & Orthotics or any other provider?

☐ Yes ☐ No | Are you currently residing in a nursing home, assisted living or group home?

If yes, name of facility: ______________________

Phone Number:______________________

☐ Yes ☐ No | Have you received a motorized wheel chair through insurance?

PAYMENT AND POLICY AGREEMENT

Your insurance policy is a contract between you and your insurance company to help you meet medical expenses. Because benefits can vary greatly, it is not possible for Virginia Prosthetics & Orthotics to provide services on the basis that your insurance company will pay all charges.

Virginia Prosthetics & Orthotics can in no way guarantee coverage. Benefits are determined by your insurance plan at the time your claim is processed. All benefit calculations are only an estimate, based on information obtained from your insurance company. The actual Total Patient's Responsibility may be different than what was previously estimated by Virginia Prosthetics & Orthotics.

To prevent any misunderstanding about medical insurance, we wish to point out that: (1) Payment for all medical services furnished are the responsibility of the patient; (2) Deductibles, co-payments, and/or other patient responsibility amounts are due at the time services are rendered; (3) For deductibles, co-insurance and non-covered custom-made devices **fifty percent (50%)** of the balance is due at the casting appointment, with the **balance due at the time of delivery**; (4) Virginia Prosthetics & Orthotics will bill your insurance company as a courtesy to you; however, Virginia Prosthetics & Orthotics is not responsible for non-payment from the insurance company; (5) If, due to unforeseen circumstances, additional procedures and/or treatments are necessary beyond what has been previously approved, patients must make arrangements for payment; (6) Patients are expected to keep their accounts current while waiting for their insurance company to remit payment.

In consideration of The Company's efforts to supply patients with products and/or services to the patient, the patient or guarantor agree that each of them is responsible for payment. Payments may be made by check, money order, Visa or MasterCard. A $20.00 fee will be assessed for any check returned for any reason.

NO REFUNDS will be given for the following items: CUSTOM MADE ITEMS, PROSTHETIC SUPPLIES (LINERS, SLEEVES, SOCKS), NON-STOCK, AND SPECIAL ORDER ITEM. All other items will be reviewed on a case by case basis.

PATIENT COMPLAINT PROCESS

We are committed to ensuring you are completely satisfied with the services and care you receive at Virginia Prosthetics & Orthotics. However, if for any reason you wish to file a complaint, any staff member can assist you in this confidential matter. You will be asked to complete a "Patient Complaint Form" to assist us in understanding your complaint or concern fully. Once the form is received, a company representative will investigate the complaint thoroughly and take the necessary actions to satisfy your complaint.

I have read and agree with the Payment and Policy Agreement. I also certify the information provided by me is true, accurate and complete to the best of my knowledge.

______________________ ______________

PATIENT/PARENT/GUARANTOR SIGNATURE DATE

______________________ ______________

PATIENT/PARENT/GUARANTOR PRINTED NAME RELATIONSHIP TO PATIENT

***If the patient is 18 or older, the patient must sign.**

VIRGINIA PROSTHETICS & ORTHOTICS PRIVACY PRACTICES ACKNOWLEDGMENT, CONSENTS, AND ASSIGNMENTS OF BENEFITS

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND COMPANY POLICIES

By signing below, I certify that Virginia Prosthetics & Orthotics, its parent company and its subsidiaries ("The Company") has made available to me a Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of Virginia Prosthetics & Orthotics healthcare operations. The Notice of Privacy Practices also describes my rights and The Company's duties with respect to my protected health information. Virginia Prosthetics & Orthotics reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy by sent in the mail, or asking for one at the time of my next appointment.

CONSENT FOR CONTACT

I, the undersigned, consent to be contacted by The Company by phone call, email, US Postal Service or other means to follow-up on my care.

CONSENT TO PROVIDE SERVICES AND/OR PRODUCTS

I understand that by signing this agreement, I indicate my wish to purchase orthotic and/or prosthetic products or services, or both, from The Company. I understand that I am under the supervision and care of my attending physician. I understand that my physician has prescribed the orthosis/prosthesis noted as part of my treatment. I also understand that due to the nature of the products supplied by The Company that they cannot be returned.

ASSIGNMENT OF BENEFITS

I, the undersigned, hereby authorize The Company to request on my/our behalf and to collect directly all public and private insurance benefits due for products and/or services supplied to me by The Company. In the event payments for insurance benefits are made directly to any of the undersigned, the payee will endorse to The Company all checks for such payments.

CONSENT TO COORDINATE CARE AND RELEASE OF MEDICAL RECORDS

By signing below, I authorize all medical personnel to provide information to The Company concerning my medical history, as it may relate to my treatment. This includes collecting medical information from any physician, surgeon, medical facility and/or physical therapist seen by me. The Company will comply with all HIPAA rules and regulations.

______________________________	______________________________
PATIENT NAME PRINTED	PATIENT DATE OF BIRTH
______________________________	______________________________
PATIENT/GUARDIAN SIGNATURE	DATE
______________________________	______________________________
GUARDIAN PRINTED NAME (If Applicable)	RELATIONSHIP TO PATIENT

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VIRGINIA PROSTHETICS & ORTHOTICS HIPAA COMPLIANCE & PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use or disclose health information. The notice contains a patient's rights section that describes your rights under the law. You verify by your signature that you have reviewed our notice before signing this consent.

The terms of the notice my change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive. By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The patient has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

I have been offered a copy of the Supplier Standards, Patient Bill of Rights and full HIPAA Privacy Standards.

I request payment of authorized Medicare and/or other insurance benefits be paid to Virginia Prosthetics & Orthotics on my behalf for any services furnished to me by Virginia Prosthetics & Orthotics. I authorize any holder of medical information about me to release any information needed to determine these benefits for related services.

MAY WE COMMINICATE WITH YOU REGARDING YOUR SERVICES & CARE VIA THE FOLLOWING METHODS?

PHONE: ☐ Yes ☐ No **E-MAIL:** ☐ Yes ☐ No **TEXT MESSAGE:** ☐ Yes ☐ No

I understand that email and test messages are not considered a completely secure form of communication and I am authorizing Virginia Prosthetics & Orthotics to send emails and/or text messages which may contain my protected health information to the following cellular devices and/or email accounts. I understand that I may change or rescind this authorization at any time by contacting Virginia Prosthetics & Orthotics.

Cell Phone ______________________ Email ______________________

MAY WE LEAVE A MESSAGE ON YOUR ANSWERING MACHINE AT HOME OR ON YOUR CELL PHONE? ☐ Yes ☐ No

MAY WE DISCUSS YOUR MEDICAL CONDITION WITH ANY MEMBER OF YOUR FAMILY? ☐ Yes ☐ No

If yes, please name the members allowed:

Name ______________________ Relationship to Patient ______________________

Name ______________________ Relationship to Patient ______________________

______________________ ______________________

PATIENT NAME PRINTED **PATIENT DATE OF BIRTH**

______________________ ______________________

PATIENT/GUARDIAN SIGNATURE **DATE**

______________________ ______________________

GUARDIAN PRINTED NAME (If Applicable) **RELATIONSHIP TO PATIENT**

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VIRGINIA PROSTHETICS & ORTHOTICS HIPAA AUTHORIZATION TO USE & DISCLOSE PROTECTED HEALTH INFORMATION – MEDIA RELEASE

1. I hereby authorize Virginia Prosthetics & Orthotics and its affiliated entities ("Clinic") and its duly authorized employees or agents, to publish use and/or disclose the protected health information that contains my name or likeness described below ("PHI"). Wholly owned clinical subsidiary.

2. The PHI that may be used and/or disclosed is my name, photo or video containing my likeness, and/or my story. This photo, video, or story may contain information relating to the diagnosis, treatment, and health care services provided or to be provided to me by the Clinic and identifies my name and other personally identifiable information. This information may be used in print media, on the radio, TV, the Clinic website, blog and on social media platforms, including but not limited to: Facebook, Twitter, Instagram, TikTok, LinkedIn and/or YouTube.

3. The PHI may be used and/or disclosed for educational, marketing, or testimonial purposes.

4. This authorization shall remain in effect until otherwise revoked.

5. The Clinic receiving health information under this authorization will not receive direct or indirect remuneration in exchange for disclosing the health information.

6. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this form.

7. I understand that, as set forth in the notice of privacy practices, I have the right to revoke this authorization, in writing, at any time, except to the extent that Clinic has acted in reliance upon it, by sending written notification to: internalcontrols@bcpgroup.net.

8. I understand that I have the right to refuse to sign this authorization.

9. I understand that PHI used or disclosed pursuant to this authorization may be redisclosed by the recipient or by social media platform(s) and its confidentiality may no longer be protected by federal or state law.

10. I understand I will receive a signed copy of this form.

11. I, on behalf of myself, or if the subject is a minor, on behalf of my minor child, hereby irrevocably permit, authorize and license Clinic and its affiliates, successors and assigns, and the employees, officers, directors and agents of each ("Authorized Persons"), to display, reproduce, edit, create derivative works, sell, rent, license, otherwise use and permit others to use my name, image, likeness, voice, and all materials created by or on behalf of Clinic that incorporate any of the foregoing ("Materials") on a perpetual basis throughout the world and in any medium or format whatsoever now existing or hereafter created for any purpose without further consent from or royalty, payment or other compensation to me.
12. I hereby irrevocably transfer and assign to Clinic my entire right, title and interest, if any, in and to the Materials and all copyrights in the Materials arising in any jurisdiction throughout the world, including the right to register and sue to enforce such copyrights against infringers. I acknowledge and agree that Clinic shall have the right to use or distribute Materials without my prior review or approval, and that Clinic has no liability to me for any editing or alteration of the Materials or for any distortion or other effects there from. Clinic has no obligation to use the Materials or to exercise any rights given by this Agreement.

Confidential & Proprietary Information — for Internal Use Only

VIRGINIA PROSTHETICS & ORTHOTICS HIPAA AUTHORIZATION TO USE & DISCLOSE PROTECTED HEALTH INFORMATION – MEDIA RELEASE

13. To the fullest extent permitted by applicable law, I hereby irrevocably waive all legal and equitable rights relating to all liabilities, claims, demands, actions, suits, damages and expenses, including but not limited to claims for copyright or trademark infringement, infringement of moral rights, defamation, invasion of rights of privacy, rights of publicity, intrusion, false light, public disclosure of private facts, physical or emotional injury or distress or any similar claim or cause of action in tort, contract or any other legal theory, now known or hereafter known in any jurisdiction throughout the world (collectively, "Claims") arising directly or indirectly from the use of the Materials and agree not to make or bring any such Claim against any Authorized Person.

14. This Agreement constitutes the sole and entire agreement of the parties with respect to the subject matter contained herein and supersedes all prior and contemporaneous understandings, agreements, representations and warranties, both written and oral, with respect to such subject matter. If any term or provision of this Agreement is invalid, illegal or unenforceable in any jurisdiction, such invalidity, illegality or unenforceability shall not affect any other term or provision of this Agreement or invalidate or render unenforceable such term or provision in any other jurisdiction. This Agreement is binding on and shall inure to the benefit of the parties hereto and their respective successors and assigns.

You acknowledge that you have read and understood all of the terms of this agreement and provide your absolute and unconditional consent, waiver and release of liability.

Name ____ Date ____

Signature____

If Participant/Releasor is a minor:
I am the parent or legal guardian of the minor named above. I have the legal right to consent to and, by signing below, I hereby do consent in all respects to the terms and conditions of this Agreement and agree that both the minor and I shall be bound by all of its terms and conditions.

Parent/Legal Guardian Name ________________________ Date ____

Signature____

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