PATIENT ID# _____

PATIENT INFORMATION *Complete sections 1 and 2 entirely, and sections 3-5 if applicable.*

1.GENERAL PATIENT INFORMATION

Today's Date____/_____/_____ Date of Birth ____/_____/_____

Name _____ Sex **F** **M**

Street _____

City _____ State _____ Zip _____

Home/Business Phone (____)_____ Cell Phone (____)_____

Social Security # _____ Referring Doctor _____

Parent/Spouse Name _____

2.PAYMENT INFORMATION

Circle One: CASH CHECK CREDIT CARD __VISA __MC__

3.INSURANCE (PRIMARY/SECONDAY) *(PLEASE PRESENT YOUR CARD TO FRONT OFFICE FOR COPY)*

If Medicare, what was your enrollment address: _____

Person responsible for bill _____ Date of Birth ____/____/_____

Address (if different) _____ Phone (____)_____

Relationship to patient _____Employer Phone (____)_____

Is this patient covered by insurance? Y N Subscriber's name _____

Subscriber's SS# _____ Date of Birth ____/____/_____

Group No._____ Policy No. _____ CoPay $_____

Patient's relationship to subscriber _____ Secondary Ins _____

4.IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address) _____

Relationship to patient _____ Phone (____)_____

The above information is true to the best of my knowledge. I authorize my insurance benefits paid directly to Mahnke's Orthotics Prosthetics. I understand that I am financially responsible for any balance. I authorize my insurance company to release any information required to process my claims.

PATIENT/GUARDIAN SIGNATURE _____ **DATE** _____

MAHNKE'S ORTHOTICS-PROSTHETICS, INC.
Orthotist/Prosthetist/Pedorthotist
Licensed by the State of Florida
Board Certified

NOTICE OF PATIENT PRIVACY PRACTICES

We are committed to preserving the privacy of your personal health information. In fact, we are required by law to protect the privacy of your medical information and to provide you with Notice describing:

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION.

We are required by law to have your written consent before we use or disclose to others your medical information for purposes of providing or arranging for your health care, the payment for or reimbursement of the care that we provide you, and the administrative activities supporting your treatment.

We may be required or permitted by certain laws to use and disclose your medical information for other purposes without your consent or authorization.

As our patient, you have important rights relating to inspecting and copying your medical information. We maintain amending or correcting that information, obtaining an account of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

We have available a detailed Notice of Privacy Practice which fully explains your rights and our obligations under the law. We may revise our Notice from time to time. The effective date at the top of your current Notice, please ask the front desk and we will provide you with a copy.

If you have any questions, concerns or complaints about the Notice or your medical information, please contact James G Newberry of our office at **Toll Free 866-236-5175.**

DATE:_____

PATIENT SIGNATURE:_____

***MAHNKE'S ORTHOTICS*-PROSTHETICS, INC.**

Orthotist/Prosthetist/Pedorthotist
Licensed by the State of Florida
Board Certified

Thank you for choosing us as your Orthotics-Prosthetics care provider.
We are committed to quality healthcare.

The following is a statement of our Financial Policy, which we ask all patients to read and sign:

There will be an ***office visit*** charge of **$30.00**. If purchase is made of prescribed item this will be included in that charge.

Financial Policy

Insurance

We cannot guarantee your benefits or eligibility with your insurance plan. Your insurance plan is a contract between you and your insurance company.

Upon completion of our Patient Information Form and your assignment of benefits, we will extend the benefit offered by your insurance company and file for reimbursement. We will handle all the paperwork for you. All payments are accepted at time of your visit for services not covered by your insurance plan. We do not accept assignment on claims under $600.00. We need proof that your deductible has been met.

If your insurance company pays only a portion of the bill or denies the claim, an explanation should be made to you, their policyholder. Reduction or rejection of your claim by your insurance company does not relieve you of financial obligation. Mahnke's will notify you if this occurs and request payment in full.

I have read the above and I understand and agree to the Mahnke's Financial Policy. I authorize the release of any medical information necessary to process insurance claims and to comply with medical reviews and audits. I also authorize payment of my benefits to be made to Mahnke's for services provided to me. I understand that the ultimate responsibility for payment of services remain mine.

Please let us know if you have any questions or concerns.

Signature _____ Date_____
Patient or Responsible Party*

* A copy of this signature is valid as the original
* Completion of this document pertains to todays and all future visits.

***MAHNKE'S ORTHOTICS*-PROSTHETICS, INC.**

Orthotist/Prosthetist/Pedorthotist
Licensed by the State of Florida
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CONSENT FOR TREATMENT / RELEASE OF MEDICAL INFORMATION AUTHORIZATION

I, _____, give my consent to **Mahnke's Orthotics/Prosthetics** to perform the following procedure/treatment and follow up care. The procedure, benefits, and limitations have been explained to me and any questions have been answered to my understanding. I hereby give informed consent for the procedure / treatment to be preformed.

I request that payment of DME/prosthetic – orthotic benefits be made on my behalf to **Mahnke's Orthotics/Prosthetics** for any services provided. I authorize any holder of medical information about me to release to **Mahnke's Orthotics/Prosthetics** or its agents any information needed to determine or receive benefits payable for related services.

I understand that the below signature(s) authorizes consent for treatment and release of medical information necessary to pay claim. I also understand that my signature authorizes benefits to be made on my behalf to **Mahnke's Orthotics/Prosthetics.**

SIGNATURE ON FILE AUTHORIZATION

(Please initial)

____I authorize my signature on this form for all insurance submissions.
____I authorize release of information to **Mahnke's Orthotics/Prosthetics** and form to **Mahnke's Orthotics/Prosthetics** in order to facilitate insurance reimbursement.
____I understand that I am personally responsible for my bill and agree to pay any portion of the bill that is not covered by Insurance.
____I authorize payment to be made directly to **Mahnke's Orthotics/Prosthetics.**
____I permit a copy of this authorization to be used in place of original.

PHOTOGRAPHIC CONSENT

____I authorize any photography of myself and my device by **Mahnke's Orthotics/Prosthetics** in connection with diagnosis, treatment, or for reimbursement purposes. Photographs will be incorporated within the patient's medical record for documentation of care.
____I hereby certify that I have read and fully understand the above provisions.

Signature_____ _____

Name _____ _____ Date ____/____/_____
(Please Print)

FORM 0908CT

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name. First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? PLACE (State) ☐ YES ☐ NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)

1. _____ 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH. # ( )

a. b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WHCF-10-ENV / WHCF-10-ENV-SS

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-1500CS