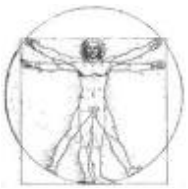

APPLIED ORTHOTICS & PROSTHETICS **PATIENT REGISTRATION FORM**

Patients Name: _____ _____ _____
(Last) (First) (Mid)

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone Number: (_____) _____ Alternate Phone: (_____) _____

Sex: _____ Date of Birth: ____/____/_____ Age: _____ Email Address: _____

Subscriber's Insurance Information, IF different from Above:

Name: _____DOB:_____Contact:_____

Are you currently residing at a skilled nursing facility? Yes____ No____ (check one)

If Yes, Name of the facility: _____

Name of Emergency Contact: _____ Relationship: _____

Home Phone Number: (_____) _____ Alternate Phone: (_____) _____

Assignment 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. 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 as valid as the original**. I also understand that all purchases are non-refundable.**

Your Signature: _____ Date: _____/_____/_____

*We accept Visa & MasterCard Only

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