KINETIC
ORTHOTICS AND PROSTHETICS

PATIENT REGISTRATION

Last Name First Name MI

Address

City State Zip

Home Phone Work Phone

Emergency Contact (EC) Name

EC Email EC Relationship Select

Date of Birth Sex Select Weight LBS Height Ft Inch

Insurance Name Insurance ID #

Secondary Insurance Name Secondary ID #

Physician Name Physician Type Select

Physician Phone

HIPAA

- Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, and the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you to read it carefully and completely before signing this Consent.
- Purpose of Consent: By signing this form, you consent for **KINETIC O & P** to use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations

COMMUNICATION AUTHORIZATION

I authorize KINETIC O & P to leave messages OR TEXT on my home phone, cell phone, or contact me by e-mail.

MEDICARE SUPPLIER STANDARDS

"The products and/or services provided to you by KINETIC O & P are subject to the supplier standards contained in the Federal regulations shown at 42 Code of Federal Regulations Section 424.57(c). These standards concern business professional and operational matters (e.g., honoring warranties and hours of operation). The full text of these standards can be obtained at http://ecfr.gpoaccess.gov. Upon request we will furnish you a written copy of the standards."

ASSIGNMENT OF BENEFITS

I authorize my insurance company to pay benefits directly to KINETIC O & P. I understand my insurance company may not pay for services that are not a covered benefit or are not considered medically necessary. I also understand that there may be benefit limitations with no-fault carriers as deductibles and benefit maximums may apply. I agree to be financially responsible for all services provided by KINETIC O & P.

I HAVE READ, UNDERSTOOD, AND HEREBY AGREE TO ALL OF THE TERMS STATED ABOVE.

PATIENT OR AUTHORIZED REPRESENTATIVE SIGNATURE: **DATE**

PRINTED NAME & RELATIONSHIP

To submit this form, please save the completed form and send in an email to tutt@kineticoandp.com