PACE Prosthetics
6631 Orion Drive Ste 110, Fort Myers, FL 33912
Phone: 239-268-4948 Fax: 239-255-5980

Patient Registration Form:

Section 1: PATIENT INFORMATION

First Name | Last Name | DOB

Address | City | State | Zip

Home Phone | Cell Phone

Social Security Number | ☐Male ☐ Female

Emergency Contact | Relation | Phone Number

Section 2: PHYSICIAN INFORMATION

Referring Physician | Phone Number

PCP | Phone Number

Section 3: INSURANCE INFORMATION

Primary | ID | Claims Address

Phone | Group Number | Primary Holder

Secondary | ID | Claims Address

Phone | Group Number | Primary Holder

Please present the coordinator with your insurance card(s) so we may make copies.

I certify that the information provided by me is true, accurate, and complete.

Signature of Patient / Guarantor | Date

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MEDICAL HISTORY FORM

Patient Name: _____ **Date:** _____

Referring Doctor: _____

Have you experienced any of the following?

☐ Heart Problems	☐ Hepatitis A or B	☐ Vision Problems
☐ Hypertension	☐ Hepatitis C	☐ Parkinson Disease
☐ Vascular Disease	☐ HIV Positive	☐ Alzheimer Disease
☐ Stroke	☐ Rheumatoid Arthritis	☐ Psychiatric Problems
☐ Diabetes	☐ Obesity	☐ Alcoholism
☐ Kidney Disease	☐ Osteoarthritis	☐ MRSA / STAPH Infection
☐ Osteoporosis	☐ Pulmonary Disease	

List any other conditions that might affect your treatment: _____

Medications that you are currently taking that might affect your treatment: _____

_____

AMPUTATIONS: _____

TRAUMAS: _____

FALLS: _____ THERAPY HISTORY: _____

Have you ever received any orthotic/prosthetic items such as braces, shoe inserts, splints, etc?

☐ Yes ☐ No When? _____

Current Height: _____ Current Weight: _____ Shoe Size: _____

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Patient Registration Signature

Patient Name: _____

I hereby authorize PACE Prosthetics to contact me regarding my care. By signing this form, I authorize PACE Prosthetics to contact me regarding appointments, treatment instructions, and billing/account information using the following contact information:

Home #: _____ Work #: _____

Mobile/Text #: _____ Email: _____

I hereby authorize PACE Prosthetics to share information regarding my treatment, or payment for treatment, with the following individuals:

☐Spouse / Partner (*name and number*)

_____

☐Children (*names and numbers*)

_____

☐Other (*relationship, name and number*)

_____

I hereby request that payment of authorized Medicare, Medicaid, or private insurance benefits be made to PACE Prosthetics or any of its subsidiaries for any covered and non-covered services furnished by PACE Prosthetics. I agree to pay to PACE Prosthetics any deductible or coinsurance owed on my claim. I authorize PACE Prosthetics to release my medical information to the Centers for Medicare and Medicaid Services or to any private insurance company that needs it to determine benefits or process payments for related services.

_____ _____

Signature of Patient or Responsible Party Date

Relationship to Patient _____

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MEDICAL RECORD RELEASE FORM

Authorization for Use or Disclosure of Protected Health Information

(*Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164*).

I authorize, (*health care provider to release information*)

_____

to use and disclose the protected health information described below to a business entity known as Reform Prosthetics. This authorization for the release of information covers all past, present, and future periods. I authorize the release of my complete health records (*including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse*). This medical information may be used by the person I authorize to by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct. This authorization shall be in force and effect until at which time this authorization form expires.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to consent to a claim. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization. I understand that information used or disclosed under this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____

Patient's Signature (or Patient's Representative)

_____ _____

Patient's Printed Name Date

HIPAA Compliance & Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may 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 practice 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.

May we phone, email, or send a text to you to confirm appointments? ☐ NO ☐ YES
- I understand that email and text messages are not considered a completely secure form of communication and I am authorizing Reform Prosthetics 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 Pace Prosthetics

Cell Phone_____ Email_____

May we leave a message on your answering machine at home or on your cell phone? ☐ NO ☐ YES

May we discuss your medical condition with any member of your family? ☐ NO ☐ YES
If YES, please name the members allowed:

Name (printed)

Signature

Date

Witness

Date

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PUBLICATION/MEDIA RELEASE

I, _____, hereby grant permission to Amputee Associates LLC and its subsidiaries to disclose my name and/or medical treatment/diagnosis or to take or have photographs/ video taken and/or interview me.

This release includes photographs, videos, interviews, and/or disclosure to be released for publication or broadcast in print, the Internet, and all other forms of media. You have the right as outlined under the privacy protection of the Healthcare Insurance Portability and Accountability Act (HIPAA) to request cessation of the use of your image in any future production of the recordings, films, or other images. Upon notification, we will cease use when the current supply is exhausted.

To make the request, please make a statement in writing to Amputee Associates LLC at 820 Fesslers Parkway, Suite 315 Nashville, TN 37210

Name: _____

Signature: _____

THIS CONSENT IS EXPRESSLY INTENDED TO RELEASE PACE PROSTHETICS, ITS EMPLOYEES, AGENTS, THE OPERATING PHYSICIAN OR PHYSICIANS, AND ANY OTHER PERSON PARTICIPATING IN MY CARE FROM ANY AND ALL LIABILITY THAT COULD RESULT FROM THE TAKING AND USE OF SUCH PHOTOGRAPHS, FILMS, INTERVIEWS, OR DESCRIPTIONS.

_____ _____

Witness Signature Signature of patient or legal guardian

_____ Address: _____

Date _____