

PACE
Prosthetics
PATIENT REGISTRATION FORM

Clinic branch

Select clinic branch

Today's date

Section 1: Patient information

First name

Last name

Date of birth

Street address

City

State

ZIP

Home phone

Cell phone

Social Security number

Sex: ☐ Male ☐ Female ☐ Non-binary / other ☐ Prefer not to answer

Gender identity (optional)

Pronouns (optional)

Emergency contact

Relationship

Phone

Section 2: Physician information

Referring physician

Phone

Primary care physician (PCP)

Phone

Section 3: Insurance information

Primary insurance

Insurance company

Member ID

Group number

Claims address

Phone

Policy holder name

Holder date of birth

Relationship to patient

Secondary insurance

Insurance company

Member ID

Group number

Claims address

Phone

Policy holder name

Holder date of birth

Relationship to patient

Please give the front desk your insurance card(s) so we can make copies. I certify that the information I have provided is true, accurate and complete.

 SIGN

Signature of patient or guarantor

Date

You will receive a copy of the Financial Policy and the Notice of Privacy Practices. Copies of your signed agreements are available upon request.

P**A****C****E**
Prosthetics
MEDICAL HISTORY FORM

Patient name

Date of birth

Today's date

Referring doctor

Have you had any of the following? (check all that apply)

- | | | |
|---|---|---|
| ☐ 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 | ☐ Neuropathy |

Other conditions that might affect your treatment

Medications you take that might affect your treatment

Your limb history

Amputations (which side, level, date, cause)

Traumas or injuries

Falls in the past 12 months (how many?)

Therapy history (PT/OT, where and when)

Have you ever had a prosthesis, brace, shoe insert or splint?

☐ Yes

☐ No

If yes, what and when?

Current height

Current weight

Shoe size



PATIENT REGISTRATION SIGNATURE FORM

Patient name

Date of birth

People we may talk to about your care

I authorize Pace Prosthetics to share information about my treatment, or payment for my treatment, with the people checked below:

☐ Spouse / partner (name and phone)

☐ Children (names and phones)

☐ Other (relationship, name and phone)

Assignment of benefits

I 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 Pace Prosthetics any deductible or coinsurance owed on my claim. I authorize Pace Prosthetics to release my medical information to the Centers for Medicare & Medicaid Services, or to any private insurance company that needs it, to determine benefits or process payment for related services.

SIGN

Signature of patient or responsible party

Date

Relationship to patient (if not the patient)

PACE
Prosthetics
MEDICAL RECORD RELEASE FORM

Authorization for Use or Disclosure of Protected Health Information (HIPAA, 45 C.F.R. 164.508)

Patient name: _____ Date of birth: _____

1. Who is sending the records

Provider or facility: _____

Phone: _____ Fax: _____

2. Who is receiving the records

Clinic (fills in from the branch chosen on page 1)

Phone

Fax

Pace Prosthetics

Address

Records are for my prosthetic or orthotic care.

3. What may be released (check one)

☐ My complete health records, including records about mental health care, communicable diseases, HIV/AIDS, and alcohol or drug abuse treatment.

☐ Only these records: _____

4. Why (check all that apply)

☐ Treatment or consultation ☐ Billing or claims payment ☐ Other: _____

5. When this authorization ends

This authorization expires on (date or event): _____

If left blank, it expires one year from the date I sign it.

6. I understand that

- I may revoke this authorization at any time by writing to Pace Prosthetics. Revoking it won't affect anything already done in reliance on it, or apply where the law gives an insurer the right to contest a claim.
- My treatment, payment, enrollment or eligibility for benefits will **not** depend on whether I sign this form.
- Information released under this authorization may be shared again by the person who receives it, and may no longer be protected by federal privacy law.
- I may have a copy of this signed form. A copy is as valid as the original.

 SIGN

Signature of patient or personal representative

Date

Printed name

If representative: relationship or authority



Pace Prosthetics

FINANCIAL POLICY

Patient name

Date of birth

Thank you for choosing Pace Prosthetics. This page explains what you're responsible for and what our staff will do for you, based on your coverage. It doesn't cover every situation; exclusions may apply depending on your plan. If your coverage changes, please tell our billing team right away. Payment plans and discounts may be available for those who qualify. We accept credit cards and checks.

If you have...	You are responsible for...	Our staff will...
In-network insurance plan	Your patient portion (coinsurance, deductible, copay), due at the time of service or after the first statement following insurance payment. With a high deductible, you may be asked for a deposit before services. Services your plan doesn't cover: payment in full on or before the date of delivery.	• Verify your eligibility, benefits and costs (copay, deductible, coinsurance) • Get authorization when required • Give you a financial responsibility estimate • Submit your claim • Send monthly statements until any balance is paid in full
Out-of-network insurance plan	Your patient portion (coinsurance, deductible, copay). Services your plan doesn't cover: payment in full on or before the date of delivery.	• Check your eligibility and out-of-network benefits • Get authorization • If a third-party billing agent offers better in-network benefits, bill through that agent to lower your out-of-pocket cost • Give you a financial responsibility estimate • Submit claims to your primary and secondary insurance • Send monthly statements until any balance is paid in full
Medicare Part B	Your patient portion (coinsurance, deductible). With no secondary insurance on file, the 20% coinsurance is due at the time of service. Services your plan doesn't cover: payment in full on or before the date of delivery.	• Verify eligibility and benefits with Medicare and any secondary insurance • Get authorization • Give you a financial responsibility estimate • Submit claims to Medicare and any secondary insurance • Send monthly statements until any balance is paid in full
Medicaid	Your patient portion (coinsurance, deductible, copay), if any. Services your plan doesn't cover: payment in full on or before the date of delivery.	• Verify eligibility and benefits with your state's Medicaid plan • Get authorization • Give you a financial responsibility estimate • Submit your claim to Medicaid • Send monthly statements until any balance is paid in full
Workers' compensation	Payment for any services not authorized or covered by workers' comp, on or before the date of delivery.	• Work with your case manager on eligibility, benefits and authorization, and submit all documentation and claims to the workers' comp plan • Give you a financial responsibility estimate, if needed
No insurance	Payment in full on or before the date of delivery.	• Help with charity paperwork if you're eligible • Give you a financial responsibility estimate before services • Send monthly statements until any balance is paid in full

[SIGN](#)

Signature of patient or responsible party

Date

Printed name



PRIVACY PRACTICES ACKNOWLEDGMENT

Acknowledgment of receipt of Notice of Privacy Practices and company policies

Patient name

Date of birth

Notice of Privacy Practices

By signing below, I confirm that Pace Prosthetics, its parent company and its subsidiaries ("the Company") made a Notice of Privacy Practices available to me. The Notice describes how my protected health information may be used and shared for my treatment, payment of my bills and the Company's health care operations, and it describes my rights and the Company's duties. The Company may change the privacy practices described in the Notice. I can get a revised copy by calling the office and asking for one to be mailed, or by asking at my next appointment.

Consent to provide services and/or products

By signing, 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, who has prescribed the orthosis or prosthesis as part of my treatment. I also understand that, because of the nature of these products, they cannot be returned.

Consent to coordinate care and release of medical records

I authorize all medical personnel to give the Company information about my medical history as it relates to my treatment, including records from any physician, surgeon, medical facility or physical therapist I have seen. The Company will comply with all HIPAA rules and regulations.

Assignment of benefits

I authorize the Company to request on my behalf, and to collect directly, all public and private insurance benefits due for products and/or services the Company supplies to me. If insurance payments are made directly to me, I will endorse those checks to the Company.

SIGN

Signature of patient or personal representative

Date

Printed name

Relationship to patient (if representative)



HIPAA CONSENT AND COMMUNICATION PREFERENCES

Patient name: _____ Date of birth: _____

Our **Notice of Privacy Practices** explains how we use and share your health information and describes your rights. Please read it before you sign. You can ask for a copy at any time.

By signing, I understand that:

- Pace Prosthetics may use and share my health information to treat me, to get paid for my care, and to run its health care operations, as HIPAA allows.
- **I have the right to ask** Pace Prosthetics to limit how my health information is used or shared. Pace Prosthetics will review every request. The law doesn't require it to agree to every limit, but if it agrees, it will follow the limit (except in an emergency). If I pay for an item or service in full myself, I can ask that information about it not be sent to my health plan, and Pace Prosthetics must agree.
- Pace Prosthetics may change its privacy practices as the law allows. An updated Notice will be available at the office and by request.
- I may revoke this consent in writing at any time. Revoking it won't undo anything already done while the consent was in place.
- Pace Prosthetics may ask that this consent be signed before treatment begins.
- Pace Prosthetics will not use my name, photos or story in any publication or marketing without my separate written permission (see the optional Publication/Media Release).

How may we contact you?

May we call, email or text you to confirm appointments? ☐ Yes ☐ No

May we leave a message on your home answering machine or cell phone voicemail? ☐ Yes ☐ No

May we send emails or texts that may include health information? ☐ Yes ☐ No

Email and text aren't completely secure. If you check Yes, we may send messages with your health information to the cell phone and email below. You can change this at any time by contacting the office.

Cell phone: _____ Email: _____

To name family members or others we may talk to about your care, use the **Registration Signature Form**.

SIGN

Signature of patient or personal representative

Date

Printed name (and relationship, if representative)

SIGN

Witness

Date

PACE
Prosthetics
PUBLICATION/MEDIA RELEASE

OPTIONAL

This form is optional. You do not have to agree to photos, video, interviews or sharing your story. Saying no will not change your care, your appointments or your bill in any way. You can change your mind later by writing to us.

Patient name: _____ Date of birth: _____

Please check ONE box:

☐ **YES**, I give permission. I agree to the items I check below:

☐ Photographs ☐ Video ☐ Interviews ☐ My name and my treatment/diagnosis

☐ **NO**, I do not give permission. Do not photograph, film or interview me, and do not share my name or my treatment information for publication. My care will not be affected.

Who this covers: Pace Health Services, Inc. (doing business as Pace Prosthetics), its parent company **Amputee Associates, LLC**, and their affiliates (together, "Pace Prosthetics and Amputee Associates").

If you checked YES: I grant permission to Pace Prosthetics and Amputee Associates to disclose my name and/or medical treatment/diagnosis or to take or have photographs/video taken and/or to interview me, **only for the items I checked above**, and to use them for publication or broadcast in print, the internet, social media and all other forms of media, including websites, newsletters, education and marketing.

Under HIPAA, you may ask us in writing to stop using your image in any future production of recordings, films or other images. Once we receive your request, we will stop using them when the current supply is exhausted. Send your request to the Pace Prosthetics clinic listed below; it applies to Amputee Associates too.

THIS CONSENT IS EXPRESSLY INTENDED TO RELEASE PACE HEALTH SERVICES, INC. (PACE PROSTHETICS), AMPUTEE ASSOCIATES, LLC, THEIR AFFILIATES, EMPLOYEES AND 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.

SIGN

Signature of patient or legal guardian

Date

SIGN

Witness

Date

Clinic: _____

Address: _____

Phone: _____ **Fax:** _____