SUNSHINE
PROSTHETICS + ORTHOTICS

Patient Registration Form

Please provide the office administrator with your insurance card

Todays date:_____

Patient name:_____SSN#_____

Address:_____DOB:_____Age:____ Gender:____

City:_____State:_____ Zip:_____ Marital Status:_____

Best phone number to reach you:_____cell/ home/ work

Other number: _____cell/home/work

Are you employed?_____ If not reason_____

Email address:_____

Would you like to be added to our email list of upcoming events?_____

Emergency Contact Name:_____ Phone#_____

Relationship to patient:_____

Referring Doctor:_____ Phone #_____

City:_____State:_____Zip:_____

How did you hear about us? (physician, therapist, insurance co, friend, website, other)

Name:_____

Have you received an orthotic or prosthetic device within the past 12 months for the condition you are being treated for today? If yes please describe.

_____

_____

_____

_____

Are you diabetic?_____If so please fill out the following:

Do you have a copy of your diabetic verification form?_____

If not who is your primary care physician or treating diabetic doctor:

Name:_____ Phone #_____

Address:_____ State:_____ Zip:_____

When was the last time you received diabetic shoes? _____

*****All patients please initial the all the above stated information is accurate. _____**

Thank you for choosing Sunshine Prosthetics and Orthotics.

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Acknowledgement of Receipt of Notice of Privacy Practices

I certify that I have received a copy of Sunshine Prosthetics and Orthotics, LLC Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of Sunshine Prosthetics and Orthotics, LLC health care operations. The Notice of Privacy Practices also describes my rights and Sunshine Prosthetics and Orthotics, LLC duties with respect to my protected health information. The Notice of Privacy Practices is located in the office lobby and is available on Sunshine Prosthetics and Orthotics, LLC website at www.sunshinepando.com.

Sunshine Prosthetics and Orthotics, LLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, asking for one at the time of my next appointment, or accessing Sunshine Prosthetics and Orthotics, LLC website.

_____

Signature of Patient or Personal Representative

_____

Name of Patient or Personal Representative

_____

Date

_____

Description of Personal Representative's Authority

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PATIENT SERVICE AGREEMENT AND FINANCIAL POLICY

The time we spend with our clients is important in order to provide the highest quality of service. Please be patient. You will receive the same courtesy and confidentiality while we are servicing you.

In order to better serve you and in partnership with your physician,Sunshine Prosthetics and Orthotics requests that you present to us the prescription from your physician at the time of service.In addition to the physician's prescription, all insurance cards, if applicable, must be presented.

We will verify all information with your insurance company. . Some insurance companies require authorization and/or referral forms. It is a requirement of your insurance company that we obtain necessary authorization or referral prior to service. Sunshine Prosthetics and Orthotics will make every effort to expedite the process, but at times, obtaining the authorization may be a lengthy process.

It is the patients responsibility to provide us with the most up to date insurance information. Failure to do so will result in a patient balance for the entire cost of device/ and or services provided.

_____ please initial

It is the patients responsibility to know their insurance policy and the their benefit coverage. If you are not familiar with your plan coverage, we recommend you contact your carrier directly. Any "patient pay" responsibilities are due at time of service.

_____ please initial

Your feedback is instrumental for improving organizational performance. Sunshine Prosthetics and Orthotics supports open communication with our patients. Please feel free to contact us at 973-696-8100 regarding care, services or payment policies.

Financial Policy Acknowledgement
I have read the above financial policy; I understand, that regardless of my insurance claim status or absence of insurance coverage, I am ultimately responsible for the balance on my account for any devices, products or services rendered. I understand that payments can be made in cash, major credit or debit card, and check.

_____ _____ _____

Patient Name (please print) Signature Date