Anew Life Prosthetics and Orthotics

6438 Woodward Avenue, Detroit, MI 48202-3216 / Phone 313-870-9610 Fax 313-870-9620

Patient Registration

Mr/Mrs/Ms/Miss _____ Date of Birth: _____

Address _____ Male _____ Female _____

City, State, Zip _____ SSN: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____ Preferred method of contact: email/phone/text

How were you referred to us? _____ Cel phone provider: _____

Emergency Contact:

Name: _____ Relation: _____ Phone: _____

Was your injury work or accident related? If so, give accident date, name and phone number of adjuster w/claim #

Are you any of the following: diabetic / in hospice care / resident of nursing home? Yes____ No____

Marital Information: Single _____ Married ____ Divorced _____ Widowed _____

Referring Physician name and phone: _____

Primary Care Physician name and phone: _____

Insurance Information:

Primary Insurance: _____

Phone/fax: _____

Member ID/claim#: _____

Secondary Insurance: _____

Phone/fax: _____

Member/claim# _____

Please provide copy of driver license, insurance card and credit card

I authorize the release of all medical information to my insurance company or doctor when requested.

I understand/agree that regardless of my insurance status, I am ultimately responsible for balance of my account for any services provided by Anew Life Prosthetics and Orthotics, LLC and/or any other collections or statement fees.

I understand that payment is expected at the time of services unless other arrangements have been made.

I give permission for Anew Life Prosthetics and Orthotics, LLC to contact me about any matters regarding my care, insurance or remuneration. I have received a copy of DMEPOS Supplier Standards, if I am a Medicare patient.

I certify this information is true, accurate and complete. I will notify Anew Life Prosthetics and Orthotics, LLC of any changes in my status regarding the above information.

Signature: _____ Date: _____

Self, parent/guardian if minor

If patient is physically or mentally unable to sign please provide the following:

Representative Relationship: _____

Representative Name (Print): _____

Representative Address: _____

Representative Phone: _____

Name on credit card or bank account: _____

Credit Card/Care Credit#: _____

Bank account name, number _____ / Routing #_____

I agree ☐

We would like to send automated text and voice messages to the mobile phone number and email you have provided. These messages will be about your scheduled appointments. By checking the box above, you agree to receive these types of messages. Consent is not a condition for or any purchase, and you can revoke your consent at any time by informing our office. Standard message and data rates may apply. You agree to notify us promptly if your mobile phone number or email address changes. This will ensure that you, and not someone else, receives messages intended for you.

Revised 12/20/2019

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6438 Woodward Avenue, Detroit, MI 48202-3216 Phone 313-870-9610 Fax 313-870-9620

Medical Release Form

I, _____ **date of birth:** _____

authorize release of my medical records to:

Anew Life Prosthetics and Orthotics
6438 Woodward Avenue
Detroit, MI 48202-3216
Phone (313) 870-9610
Fax (313) 870-9620

This Notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). We are strongly committed to protecting your medical information, also referred to as "Protected Health Information". We create a medical record about your care because we need the record to provide you with appropriate treatment and to comply with various legal requirements. We transmit some medical information about your care in order to obtain payment for the services you receive, and we use certain information in our day-to-day operations. This Notice will let you know about the various ways we use and disclose your Protected Health Information. This Notice describes your rights and our obligations with respect to the use or disclosure of your Protected Health Information.

OUR DUTIES TO YOU REGARDING PROTECTED HEALTH INFORMATION

"Protected Health Information" is individually identifiable health information. This information related to your past, present, or future physical or mental health or condition and related health care services; to the past, present or future payment for such health care services; and includes demographic information such as your age, address or e-mail address. Anew Life is required by law to do the following:

- Make sure that your Protected Health Information is kept private.
- Give you this Notice of our legal duties and privacy practices related to the use and disclosure of your Protected Health Information.
- Follow the terms of the Notice currently in effect.
- Describe how we will communicate any changes in this Notice to you.

Signature: _____ Date: _____

Self, parent/ or guardian if minor

If unable to sign:

Patient Name: _____ **(Please print)**

Signature by: _____ Date: _____

Representative

Representative Name: _____

Representative Address: _____

Representative Relationship: _____

(Please print)

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Authorization of Payment

Patient Name: _____

Primary Insurance: _____

Secondary Insurance: _____

I instruct my insurance company to pay by check or ACH credit to "Anew Life Prosthetics and Orthotics LLC".

If my insurance prohibits direct payment to "Anew Life Prosthetics and Orthotics LLC", I instruct my insurance company to pay "Anew Life Prosthetics and Orthotics, LLC" on my behalf via check or AHC credit. Check should be made payable to "Anew Life Prosthetics and Orthotics, LLC" and sent to:

Anew Life Prosthetics and Orthotics
6438 Woodward Avenue
Detroit, MI 48202-3216

The professional or medical benefits allowable and otherwise payable under my current insurance policy are payment toward the charges for the professional services rendered. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebteness to the above, and I have to pay, in a current manner, any balance due over and above the insurance payment.

I request that payments of Medigap or other benefits be made to "Anew Life Prosthetics and Orthotics, LLC" for any services furnished to me by this provider. I authorize any holder of medical information to release to my Medigap or other insurance any information needed to determine these benefits payable for related Services. I agree that if updated insurance information is not provided at the time of service and/or time filing limitations has expired, I am responsible for the charges. I authorize Anew Life Prosthetics and Orthotics to initiate to the insurance Commissioner for any reason on my behalf.

It is not Anew Life Prosthetics and Orthotics, LLC responsibility to know my insurance benefits nor their responsibility to check my insurance benefits at time of service, it is done as a courtesy. Any information received from my insurance company regarding eligibility or benefits is not a guarantee of payment.

Please refer to cancellation policy also given to you with the other required documents.

A photo copy of this agreement shall be considered as effective and valid as the original.

Signature: _____ **Date:** _____

Self, parent/ or guardian if minor

Patient Name: _____ **patient is physically or mentally (circle) unable to sign**

Signature by: _____ **Date:** _____

Representative Name/Relationship: _____ **(Print)**

Representative Address:

Credit Card Policy

ANEW LIFE
—Prosthetics and Orthotics—

At Anew Life Prosthetics and Orthotics, we require keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance may or may not cover, but for which you may be liable. **Without this authorization, a billing fee of $25.00 will be added to your account for any balances that we must attempt to collect through mailing monthly statement. Furthermore, an "outstanding balance" charge of 1.5 percent of the total bill will charged for each month that the bill remains unpaid.**

Your credit card information is kept confidential and secure. Payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account.

I authorize Anew Life Prosthetics and Orthotics, to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

☐Amex ☐Visa ☐Mastercard ☐Discover Credit

Card Number _____

Expiration Date _____ / _____ / _____

Cardholder Name _____

Billing Address _____

City _____ State_____ Zip _____

I (we), the undersigned, authorize and request Anew Life Prosthetics and Orthotics, to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility. This authorization relates to all payments not covered by my insurance company for services provided to me by Anew Life Prosthetics and Orthotics. This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60 day notification to Anew Life Prosthetics and Orthotics in writing and the account must be in good standing.

Patient Signature: _____ Date: ___ - ___ - ____

Revised Date 03-01-2019

6438 Woodward Avenue Detroit, MI 48202-3216
Phone 313-870-9610 Fax: 313-870-9620 E: Info@anewlifepando.com

Patient History Form

Name: _____ DOB: _____

Briefly describe your present symptoms related to today's office visit.

_____

_____

Please list the names of other practitioners and/or physicians you have seen for this problem.

_____

_____

General Health: Fair Poor Good Excellent

Personal History

Are you condition results of an accident? If, yes: Auto Work Other: _____

Date of Injury: _____ Type: Traumatic Acquired Congenital

Amputation Level: _____

What is your highest education? _____

What is your current or past occupation? _____

If still currently working what are you number of Hours/Week: _____

Personal Medical History: Do you now or have you ever had the following conditions?

☐ Alzheimer Disease	☐ Arthritis	☐ Alcoholism
☐ Cancer	☐ COPD/Asthma	☐ Congestive Heart Failure
☐ Depression	☐ Diabetes	☐ Heart Disease
☐ Hepatitis	☐ HIV/AIDS	☐ Hypertension/Hypotension
☐ Smoking	☐ GERD	☐ Glaucoma
☐ Kidney Disease	☐ Osteoporosis	☐ Pulmonary Disease
☐ Pacemaker/Defibrillator	☐ Parkinson's Disease	☐ Seizures
☐ Smoking/Vaping	☐ Dialysis	☐ Drug Usage
☐ Vascular Disease/PVD	☐ Currently Pregnant	☐ Other: _____

List Any Medication: _____

_____

_____

Continue to other side of page.

Patient History Form

List of any other conditions that you feel might affect your treatment (including date and descriptions of surgeries): _____

_____

_____

_____

List of Any Surgeries and Surgeons: _____

_____

_____

_____

Do you have any prior prosthetic/orthotic experience? If yes, briefly explain. _____

_____

_____

Therapy: Occupational Physical # of Days per Week: ____ On (Circle): M T W T F

List of all known allergies: _____

_____

Other Additional Information: _____

_____

_____

_____

Office Use ONLY

Height:_____ Weight: _____lbs. Temperature: _____°F Blood Pressure: _____/_____

Pulse:_____bpm in sitting position Oximeter: _____%$Sp0_2$ Initial & Date: _____

Sign: _____ Date: _____

Revised: 05-01-2019

Anew Life Prosthetics and Orthotics LLC
6438 Woodward Avenue Detroit, MI 48202
P: 313-870-9610 F: 313-870-9620

HIPAA Documents and Supplier Standards Receipt

I, _____, have received the following document(s) on

____/____/____, and I agree to the terms listed within them:

Document Name	Description
Anew Life Patient Intake Form	Patient Registration Form where all fields are completed by patient.
Appointment Policy	Patient responsibilities of appointments held at Anew Life Prosthetics and Orthotics LLC.
Authorization of Payment	Authorization of payment form where all fields are to be completed by patient.
Credit Card Policy	Credit Card policy and form kept in patient file.
Financial Responsibility Information	Financial responsibility information based on insurance type.
Financial Responsibility Notice	Patient notice of financial responsibilities policy with Anew Life Prosthetics and Orthotics LLC.
Medical History	A form completed by patient regarding their medical history information.
Medical Release Form	Medical Release of Information form where all fields are completed by patient.
Medicare Standards	Mandated federal standard policies and procedures applicable.
Patient Rights	Patient right and responsibilities for Anew Life Prosthetics and Orthotics LLC to provide product/service.

_____ _____

Signature Date

Notice of Confidentially: This document contains unconditionally private medical records. Any improper use of the information contained herein constitutes a breach of patient medical confidentiality.