San Francisco Prosthetic Orthotic Service, Inc.

Demographic Information

PATIENT NAME:	BIRTH DATE:	SEX: MALE FEMALE
ADDRESS:	HOME PHONE:	CELL PHONE:
ADDRESS:	SOC SEC #	PRIMARY PHYSICIAN
CITY:	PRIMARY PHYSICIAN:	REFERRING PHYSICIAN:
STATE: ZIP CODE	EMAIL:	

Insurance Information - please present card(s) and photo identification for verification

PRIMARY INSURANCE	INSURED UNDER: (CIRCLE) SELF PARTNER PARENT	ID#
IF INSURED UNDER SOMEONE ELSE, PRIMARY INSURED'S NAME:	PRIMARY'S BIRTH DATE:	PRIMARY'S PHONE NUMBER:

SECONDARY INSURANCE	INSURED UNDER: (CIRCLE) SELF PARTNER PARENT	ID#
IF INSURED UNDER SOMEONE ELSE, PRIMARY INSURED'S NAME:	PRIMARY'S BIRTH DATE:	PRIMARY'S PHONE NUMBER:

Workman's Comp (IF APPLICABLE)

CARRIER:	CLAIM #:	DATE OF INJURY:
EMPLOYER:	ADJUSTOR:	ADJUSTOR PHONE:

Patient Medical Information

1. Are you diabetic? _____ Type I or II _____

Physician Managing Diabetes: _____ Date of last exam: _____

2. Are an amputee? _____ Date of amputation: _____

Physician Managing Residual Limb: _____ Date of last exam: _____

3. Have you been hosptialized for surgery or serious illness within the last 5 years?

If yes, date(s) of inpatient stay _____

Signature and Service Agreement

By signing this form I attest all information to be true to the best of knowledge. I also authorize San Francisco Prosthetic Orthotic Service, Inc. (SFPOS) to bill my insurance company(s) for devices and or services. Payment for devices and or services will be made to San Francisco Prosthetic Orthotic Service, Inc. I understand that I am ultimately responsible for payment of devices and services provided by SFPOS. I understand that if my insurance requires authorization and I choose to receive devices and or services before written authorization has been received by SFPOS, that I accept financial responsibility for all charges. **I understand that authorization is not a guarantee of payment; only an agreement of medical necessity by my insurance.** I also understand that my insurance company may deduct Co-Pay and/or Deductible amounts from their payment to SFPOS, and **I agree to pay these amounts at time of service or when billed at a later date.** If my account is turned over to collections due to non-payment, I agree to pay any fees associated with the collection process. I accept delivery and financial obligation of custom made or special order items. I authorize SFPOS to bill me and/or my insurance for any items that I do not pick up within 90 days that have been custom made or special ordered. I authorize SFPOS to ship any items or components to me that have been billed due to not being picked up. **I also grant permission to call me in order to schedule, confirm, or reschedule an appointment.**

_____ _____

Signature of patient or personal representative Date

_____ _____

Printed Name of personal representative Relationship to patient

REVISED 02/01/15