122 North 5th Street Boise, ID 83702
P (208)342-4659 F (208)342-8211

Today's Date:______________________

Patient Information

Last Name:____________________ First Name:_______________ MI:_______
Date of Birth:_________________ Age:__________Gender:______________
SSN:_____________________________
Email:____________________________________ Marital Status:___________
Phone Number:______________________ Work:_________________________
Cell:_______________________________________
Address:____
City:___________________ State:_______________ Zip:___________________
Occupation:____
Employer:____
Spouse's Name:____
Spouse's Date of Birth:___________________

Physician Information

Referring Physician (the Dr. that signed your Rx):____________________________
Phone Number:____________________________

Primary Care Physician: ________________________
Phone Number:____________________________

Healthy Connection Physician (this is if you have Medicaid):_________________
Phone Number:______________________

Insurance Information

Primary Insurance: ____
Policyholder Name:____
Policyholder date of birth:____________________
Relationship to Patient: ______________________
Policy Number: ____________________________
Group Number: ____________________________

Secondary Insurance: ____
Policyholder Name: ____
Policyholder date of birth: ___________________
Relationship to Patient:______________________
Policy Number:____________________________
Group Number:____________________________

Labor and Industry/Worker's Comp Company:____________________________
Claim Number: ____
Date of Injury:____
Employer at time of Injury:____
Claim Adjuster Name:____
Phone Number:____

In Case of Emergency

Name of Local Friend or Relative:____
Relationship to Patient:____
Address:____
Home Phone Number: ____
Work Phone Number:____

Other Health Information

Is your injury the result of an auto accident? YES NO
Are you diabetic? YES NO
Have you had the same or a similar item/equipment in the past? YES NO
If yes, when/where?____

Are you currently residing in a Skilled Nursing Facility? YES NO
If yes, name of facility:____
Contact person and number:____

PRIVATE INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE

I authorize payment of medical benefits to Brownfield's Prosthetic & Orthotic Technologies for any services furnished to me (or to the patient for whom I am the responsible party) by the Practitioners. I understand that I am financially responsible for any amount not covered by my insurance. I authorize you to release to my insurance company information concerning health care, advice, treatment, or supplies provided to me. I understand that I am financially responsible for services provided to me if I am uninsured.

MEDICARE LIFETIME SIGNATURE ON FILE

I request that payment of authorized Medicare benefits be made on my behalf to Brownfield's Prosthetic & Orthotic Technologies for any services provided to me by the Practitioners. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits payable for related services.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I certify that I have received a copy of Brownfield's Prosthetics & Orthotics 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 Brownfield's Prosthetic & Orthotic Technologies health care operations. The Notice of Privacy Practices also describes my rights and Brownfield's Prosthetic & Orthotic Technologies duties with respect to my protected health information. The Notice of Privacy Practices is posted in the front office.

Brownfield's Prosthetic & Orthotic Technologies 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 to me in the mail or by asking for one at the time of my next appointment.

FRIENDS AND FAMILY RELEASE

The name(s) listed below are family or friends to whom I wish to grant access to my health care and/or billing information, as they deem necessary. I understand that information is limited to verbal discussion and that no paper copies of my PHI information will be provided without my signature to release any "sensitive" information.

The consent will be considered called until such time that I revoke it. I reserve the right to revoke it at any time. It will be my responsibility to keep this information up to date, as I recognize that relationships and friendships change over time.

Name:_________________________ Relationship:___________________ Phone:___________

Name:_________________________ Relationship:___________________ Phone:___________

Name:_________________________ Relationship:___________________ Phone:___________

X ____

PATIENT/GUARDIAN SIGNATURE DATE