POWELL
spirit. support. science.

2034 Dabney Rd., Ste. C Ph: (804) 649-9043
Richmond, Va. 23230 Fax: (804) 783-8212

PATIENT INFORMATION

Thank you for selecting Powell Orthotics & Prosthetics. In order to serve you properly, PLEASE PRINT all of the following information. All information will be kept confidential, according to HIPPA regulations.

Patient Name____ **Gender: M or F** **Today's Date:** _________________

Address____ **City**_________________________ **State**______ **Zip**_________

Home Phone (   ) ________-__________ **Work Phone (   )** ______-__________ **Cell (   )** _______-___________

Email Address ____

Patient's Social Security #______________________________ **Patient's Date of Birth** _____________________________

Relationship to Patient________________________ **Parent, guardian, or spouse's name** _________________________________

Which body part /area are we treating, please be specific____

Reason for Treatment (Diagnosis) ____

Date of Injury or amputation if applicable ________________________

I authorize treatment for the condition described above by Powell Orthotics & Prosthetics.

Signature of Patient, Guardian or parent if patient is a minor **Date**

PHYSICIAN INFORMATION

Referring Physician____ **Phone (   )** _______-___________

Primary Care Physician____ **Phone (   )** _______-___________

Medicare Assign of Benefits

I request that payment of authorized Medicare benefits be made on my behalf for any services furnished me by *Thomas G. Powell ,Inc*. I authorize any holder of medical information or other information about me to release to the health care financing administration and its agents any information needed to determine these benefits.

Signature of Patient, Guardian or parent if patient is a minor **Date**

Please Turn Over & Fill Out Completely

INSURANCE INFORMATION

As a courtesy, we call your insurance company to check the benefits for the orthotic/prosthetic equipment prescribed for you. Any benefit information quoted to you is based on the information obtained from the insurance company and is not a guarantee of you benefits or payment. We will assist in obtaining an authorization for the equipment when required and will not release any merchandise until authorization and all co-insurance and deductibles are paid in full.

INSURANCE COMPANY ____ Identification Number__________________________

Name of *Policy Holder* ____ Relationship to Patient_________________________

Date of Birth *of Policy Holder*________________ SSN of Policy Holder: _______-_____-_______ Employer _________________

If different from above: Address______________________________ City________________ State_________ Zip____________

Home Phone ( ) ______-___________ Work Phone ( ) _______-__________ Cell ( ) _______-__________

Is this a worker's compensation claim? No YES : Date of Injury: ______/______/______

SECONDARY INSURANCE ____ Identification Number__________________________

Name *Policy Holder* _______________________Relationship to Patient ___________Date of Birth *of Policy Holder*____________

Address (if *different)* _______________________________City__________ State____ Zip_______ Phone ( ) ______-__________

I authorize the release of health information concerning me or my child's health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize my insurance company to pay directly to ***Thomas G. Powell, Inc. / Powell Orthotics & Prosthetics,*** insurance benefits otherwise payable to me. I understand my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on me or my dependents behalf. Please contact us if an item you have received does not fit properly. No returns will be accepted after three (3) business days. I agree to pay all costs incurred in the collection process, including court costs and attorney fees.

Signature of Patient, Guardian or parent if patient is a minor Date

PAYMENT POLICY

I understand that I will be fully responsible for any balance due and owing on this or any account that I might have with ***THOMAS G. POWELL, INC***. Should an account become delinquent beyond 30 days, I understand that it may be turned over to an attorney for collection. In this event, I understand that I will be responsible for all court cost & attorney fees up to 33-1/3 %. I also agree to pay 1-1/2% (18% Per Annum) interest on any balance over 30 days.

I further understand that in the event an account is delinquent, ***THOMAS G. POWELL, INC.*** may suspend any and all work and/or repair to devices which I have purchased from them until such time as my account is brought current and I waive my rights to hold ***THOMAS G. POWELL, INC***. liable for any negligence or damages resulting from their suspension of work due to my delinquent account.

I further understand there are NO REFUNDS on ***CUSTOM MADE ITEMS, SURGICAL GARMENTS, HOSIERY, NON-STOCK, OR SPECIAL ORDER ITEMS.*** All other merchandise must be accompanied by your receipt.

My signature assigns benefit to ***THOMAS G. POWELL, INC***. for services rendered. I agree to notify Thomas G. Powell, Inc. immediately of any change in insurance coverage or status.

Signature of Patient, Guardian or parent if patient is a minor Date