Level Four Orthotics & Prosthetics,Inc, Orthopartners Inc, WR Rosen, Inc, American Ortho-Tech Laboratories Inc, Cocco Enterprises, Inc.

Registration Form

***Must be accompanied by Photo Identification and Insurance Card Copies Front/Back**

Social Security # of patient _____- _____ - _____ Patient's Date of Birth_____

Patient's FULL Name_____
LAST FIRST MI

Patient's Address: _____

City _____ State _____ Zip _____

Home Phone: _____ Work Phone (Parent's work phone if minor): _____

Cell Phone #:_____Marital Status: _____Single _____Married _____Divorced _____Other

EMAIL ADDRESS: _____ Sex: _____M _____F

Parent(s) of Minor or Guardian _____ Social security # _____

Relationship to Patient_____ Power of Attorney: Circle One Yes or No

***A Copy of Parent/Guardian or Financially Responsible Party's License REQUIRED**

Guardian Date of Birth: _____ Address _____

City/State/ZIP _____ Phone _____

Prescribing Physician _____Primary Physician _____

PRIMARY Insurance Carrier _____ Group Name/#_____

Policy ID#: _____ Policy Holder's Name: _____

Policy Holder's SS#: _____ DOB_____ Relationship to patient_____

SECONDARY Insurance Carrier _____ Group Name/#_____

Policy ID#: _____Policy Holder's Name: _____

Policy Holder's SS#: _____ DOB_____ Relationship to patient_____

Authorization to Release Necessary Information to Necessary vendor/insurers to authorize, manufacture and/or bill required device

I hereby authorize LEVEL FOUR O & P INC. to release necessary information, including photographs or clinical information in order for my necessary and prescribed device(s) to be authorized, manufactured and reimbursed by my insurer. I consent to treatment by Level Four Orthotics and Prosthetics and consent to have photographs of my condition taken if necessary for clinical documentation. Digital scans can be used without Protected Health Information for educational purposes.

Authorization To Pay Benefits To Level Four/Authorization to Release Information

I hereby authorize payment directly to LEVEL FOUR O & P INC. for any services I receive during my treatment. I give permission to LEVEL FOUR O & P INC., Inc to release any information to my insurance company, attorney, assignees and/or beneficiaries needed for payment.

Financial Responsibility and Contact Permission

I understand I am responsible for services rendered in the event insurance does not cover all fees. I understand that I can be provided an estimate of charges, however the terms of insurance contract state authorization and verification are not guarantees of payment and I understand that I am responsible per the Explanation of Benefits. Permission hereby is granted to call telephone numbers listed for purposes including but not limited to scheduling, confirmation calls or to collect a payment. We will not disclose any Protected Health Information with anyone not indicated on subsequent forms.

Signature: _____ Date: _____

LEVEL 4
ORTHOTICS - PROSTHETICS - CRANIAL REMOLDING

Level Four Orthotics & Prosthetics,Inc, Orthopartners Inc, WR Rosen, Inc, American Ortho-Tech Laboratories Inc, Cocco Enterprises, Inc.

Signed Acknowledgments

Patient Name_____

Protected Health Information Contact/HIPAA

I give Level Four permission to contact me at the number(s) on my registration or demographics for purposes including but not limited to scheduling, clinical information, confirmations, follow up and contact regarding billing.
Level Four may also speak to the following (Please Circle All That Apply and Add Name)

Spouse/Partner _____ Child(ren) _____
Parent/Guardian_____ Other_____ None

I undersign that I have been offered a current copy of Level Four's Notice of Privacy Practices as well as Medicare Supplier Standards for Medicare beneficiaries. Products and Services provided to you are covered under federal regulation 42 CFR 424.57(c).
I give Level Four permission to request necessary Medical Records from my physicians to authorize or comply with coverage requirements for my device. I may be asked to sign a specific release if my physician requires an Authorization to Release Medical Information.
I authorize email of survey from Quality Outcomes if included in Registration Form for our Quality Assurance Program as well as communication attempts if needed.
I agree to have photographs taken of my condition for clinical documentation if required. If for Marketing purposes a separate release will need to be signed.

Please answer the following to Assist Us In Verifying Insurance Benefits, If you are unsure, ask for help from our staff.

Have you received a similar item within 5 years? Circle One Yes or No

Are you a resident in a Skilled Nursing Facility? Circle One Yes or No

Are you in Hospice Care? Circle One Yes or No

Financial Estimates and Payment Policies

I understand that I am responsible for any applicable coinsurance, deductible, out of pocket charges deemed by my insurer or non covered services. We verify every insurance benefit fully, however verification of benefits and authorization are not guarantees of payment. We can provide you with an estimate of insurance charges. Coinsurance and deductibles are due at time of service. Minimum of a 50% deposit of coinsurance on custom devices or ordered items is required at time of order and payment in full is required by delivery.

Custom items as prescribed by a physician are not returnable or refundable. If I do not respond to attempts to fit my custom prescribed device, if a Salvage Claim cannot be filed to my insurer, I will become personally responsible for full payment. If Level 4 disagrees with how insurance benefits were applied, I hereby grant Level 4 permission to prepare and file an appeal on my behalf.

Warranty

Specific device warranty will be provided on delivery of your device. We have a 90 day service policy in which to make repairs free of charge as long as the device has not been altered. If the device is altered by any person other outside of Level Four or is subject to neglect, abuse or misuse, the warranty will become void. If the patient does not comply with verbal or written instruction, care or wear schedule, the warranty may also be void.

Signature: _____ Date: _____