OrthoSource

Durable Medical Equipment

14441 F Street
Omaha, Nebraska 68137
Phone: (402) 408-0777
Billing: (402) 614-7775

Patient Registration Information

PERSONAL INFORMATION

Patient Name _____ SS# _____ Date of Birth ___/___/___
First Middle Initial Last MM DD YY

Age _____

Address _____
Street, PO Box Apt. #

Sex Male Female (Circle One) Status Single Married Other (Circle One)

_____
City State Zip Code

Patient's Employer _____

Home or Cell Phone ( ) _____

Address _____
Street, PO Box Suite #

Alternate/Emergency Phone ( ) _____

_____
City State Zip Code

Parent or Spouse Name _____
(Circle One)

_____
Work Phone Number

Referral Information

Referring Physician _____

Date Last Seen By Physician _____

Primary Care Physician (HMO patients only) _____

Insurance Information

Insurance Company Name _____
PPO HMO POS Group Private MVA
(Circle One)

Secondary Insurance Name _____
PPO HMO POS Group Private MVA
(Circle One)

Injury Information – PLEASE COMPLETE

Cause of Injury _____

Date of Injury _____

Work Related? Yes No

Work Comp Contact _____

Work Comp Insurance _____

Phone ( ) _____

Consent for Treatment/ Receive Product. I hereby give my consent to receive the product by this provider as directed by my referring physician.
Consent to the Use and Disclose Health Information. I understand that as part of my healthcare, this practice originates and maintains my records and information related to the products I have been prescribed. I understand and accept the terms of this consent. A full copy of this policy can be viewed by request.
Authorization to Release Payment and Information. I request that payment of authorized insurance benefits be made either to me or on my behalf to OrthoSource, Inc. for any services furnished me by a rehabilitation provider employed by same. I authorize any holder of medical information about me to release to my insurance carrier and its agents any information needed to determine these benefits or the benefits payable for related services.
Our Payment Policy. As a service to you, our office will bill all insurance. However, you are responsible to us for payment of your balance. Payments can be made at any time to our office. If you do not have any insurance, payment is expected at the time services are rendered.

Signature _____ Date _____

Note. If you are 18 years of age or younger, a parent or guardian must sign this patient registration form on your behalf

Your signature on this form indicates that you have received the prescribed product

Diagnosis _____ *Area Treated* _____ *Start Date* _____

Office Use Only

HCPCS CODE(S) _____

Affix product label here or record product information