CERTIFIED

Certified Prosthetics & Orthotics, LLC
Fort Collins • Greeley • Denver
Toll Free 1-800-466-7015
www.certifiedop.com

# PATIENT INFORMATION

Today's Date: _____

Patient's Name: _____
First M.I. Last

Address: _____
Street City State Zip

Date of Birth: _____ Sex: _____ Social Security #: _____

Phone: _____ Work/Other: _____ Cell: _____

Email Address: _____

If patient is under 18, parent's name, address & phone # _____

_____

Emergency Contact if not listed above: Name: _____

Relationship: _____ Phone: _____

Primary Care Physician _____

*Please INITIAL and SIGN the following statements:*

_____ I consent that CERTIFIED may use and disclose my Protected Health Information to carry out treatment, payment and healthcare operations.

_____ I acknowledge that the Privacy Practices of CERTIFIED were made available for my review.

_____ I have reviewed the Financial Policy and agree to follow the guidelines set forth.

_____ I give my permission to release all of my medical-related information to the following person if I cannot be reached.

Name: _____ Relationship: _____

_____ I **DO / DO NOT** (circle one) give my permission for CERTIFIED to leave detailed information regarding my medical care at the folowing phone number.

***As a courtesy to our patients, we will gladly bill your insurance; however, insurance benefits quoted are not a guarantee of payment. Actual benefits will be determined by your insurance company upon receipt of our claim. All outstanding payments due are ultimately the responsibility of the patient or the responsible person listed above.***

_____ _____

Signature Date