Brownfield's
PROSTHETICS & ORTHOTICS *restoring independence | renewing lives*

PATIENT INFORMATION

Last Name: ______________________ First Name: ________________ MI: _____

Date of Birth: ___________ Gender: _____ SSN (last 4 for Veterans): ________________

Address: ____

City/State/Zip: ____

Home phone: ___________ Work phone: __________ Cell phone: ______________

Email Address: ___________________________ Marital Status: ______________

Occupation: ☐ Employed ☐ Student ☐ Not Working ☐ Retired ☐ Child ☐ Other: __________

Preferred method of contact: ☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ Email

How would you like to be notified for appointment reminders: ☐ Phone Call ☐ Email

The name(s) listed below are family or friends to whom I wish to grant limited verbal discussion concerning my health care and/or billing information, as they deem necessary. This consent will be my responsibility to update, as I recognize that relationships and friendships change over time.

Name: ___________________ Relationship: ____________ Phone: ____________
Name: ___________________ Relationship: ____________ Phone: ____________

Referring Physician (Doctor who signed your prescription): ___________________________

Primary Care Physician (Your main doctor): ________________________________

Is your injury the result of: ☐ Auto Accident? ☐ Workman's Comp? ☐ N/A

Are you diabetic? ☐ NO ☐ YES (Type I) ☐ **YES** (Type II)
Who is the doctor who treats your diabetes? ____________________________

Have you had the same or a similar item/equipment in the past? ☐ NO ☐ YES

When and where did you get the item? ________________________________

If Patient is a minor child- Info for Responsible Party (Parent or Guardian)

Name: _________________________ Phone: __________________________

Address: ____________________________ Relationship: _________________

Is Patient Currently Residing in a Skilled Nursing Facility? ☐ NO ☐ YES

If yes, name of facility: __________________________ Date Admitted: __________

Please complete back side.

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INSURANCE INFORMATION

A copy of your picture ID & insurance cards are required (Veterans may skip this section)

Primary Insurance: ____________________
Insured's Name: ____________________
Insured's Date of Birth: ____________________
Insured's employer: ____________________

Secondary Insurance: ____________________
Insured's Name: ____________________
Insured's Date of Birth: ____________________
Insured's employer: ____________________

WORKER'S COMPENSATION INFORMATION (If applicable)

Worker's Comp Insurance Carrier: ____________________
Claim No. ____________________ Date of Injury: ____________________
Insurance Contact: ____________________ Phone: ____________________

PAYMENT & PROVISION OF SERVICES

Although Brownfield's will bill your insurance company, the final balance is your responsibility and is due within 60 days of delivery. For custom products NOT covered by insurance, Brownfield's requests a 50 percent down payment before placing an order or beginning manufacture.

ALL CUSTOM ITEMS ARE NON-REFUNDABLE

I HEREBY AUTHORIZE Brownfield's Prosthetic & Orthotic Technologies to bill my payer of medical benefits for services which I have received, and assign payment for those services to Brownfield's. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any services rendered. I also authorize Brownfield's to release to the payer of medical benefits, or any of its agents, any medical or other information needed to determine payment of these benefits or benefits for related services. I certify that the information I provided is true and correct to the best of my knowledge. I will notify Brownfield's of any change to the above information. I understand that by disclosing my email address, Brownfield's employees may contact me with protected health information, and I assume responsibility for such.

SIGNATURE ____________________ **DATE** ____________________