Orthotic CARE SERVICES

PATIENT DEMOGRAPHIC FORM

Patient Information

First Name:	Last Name:	Middle Initial:	Nickname:

DOB:	Gender:	Interpreter Needed? Yes or No If yes, language: _____

Contact Information

Guardian 1 (First & Last Name):	Guardian 2 (First & Last Name):

Address:

City:	State:	Zip Code:

Phone (Preferred):	Phone (Secondary):	Email:

Is it ok to leave a confidential voicemail? Yes or No	Is it ok text? Yes or No

Patient Medical Information

Seen by physician within the past 4-5 months? Yes / No Date: _____	Primary Physician:	Clinic Name:

Physical Therapist:	Clinic Name:

Insurance Information

Primary Insurance Carrier:	Policy Holder DOB:

Primary Insurance Policy Holder:	Primary Insurance ID Number:

Secondary Insurance Carrier:	Secondary Holder DOB:

Secondary Insurance Policy Holder:	Secondary Insurance ID Number:

PATIENT CONSENT FORM

Please initial on each of the lines:

_____ I agree to voluntarily consent to the use of diagnostic procedures and medical treatment as ordered by the prescribing physician, their assistants, or consultants as is necessary in their judgment.

_____ I understand that the prescribing doctor must have seen my child in the last six months, where an orthosis has been discussed. I understand that I am responsible for obtaining referrals from the prescribing doctor, if necessary. Otherwise, the entire cost of the item will be my responsibility.

_____ I hereby authorize Orthotic Care Services, LLP to release medical information regarding myself or my child, related patient's condition, and treatment to their insurance company for purposes of payment and/or quality review. Additionally, I agree to the release of information to referring, treating, consulting physicians or other medical providers when necessary to provide continuity of care for myself or my child. This authorization remains valid until I exercise my right to revoke it in writing.

_____ I authorize payment directly to Orthotic Care Services, LLP for the benefits due under the provisions of my health insurance policy or other payers for these services. I agree that I am responsible for full payment at the time of service if I have not provided insurance information or if coverage on these services has been denied. I understand that I am fully responsible for all charges incurred in the event of a denial by my insurance carrier.

_____ I understand that OCS's Notice of Privacy Practices and Billing Process and Collection Policy are available online through the OCS Website (www.orthoticcareservices.com). I understand that a current copy of each document may be obtained at any time.

Photo/Video Collection and Release (Optional): Please initial on each of the lines you are comfortable with.

I authorize the collection and use of photographs and/or video:

_____ During any appointments with Orthotic Care Services, LLP. These photos/videos will be stored in your child's chart and be used for diagnostic purposes only. This is commonly done during Lowers Program appointments and required for Helmet Program appointments (3D Scan).

_____ For the purposes of research and teaching. I understand that any research may be published in scientific journals, magazines, or other publications. The patient's or family's name may not be used unless additional permission is given.

_____ I consent to allow my child's first name to be used as notated above.

_____ As testimonials on the OCS Website, OCS Social Media pages (Facebook, Instagram, YouTube). The patient's or family's name may not be used unless additional permission is given.

_____ I consent to allow my child's first name to be used as notated above.

I understand this release is based on the following conditions:

- These records become the property of Orthotic Care Services, LLP, or its representatives.
- I release and waive all claims to compensation and rights regarding such use and/or publication.
- The parent/legal guardian and the patient release to Orthotic Care Services, LLP any right, title, and/or interest of any kind they may have in the records produced.
- This release is effective until revoked in writing by the undersigned. Such revocation shall only be effective to prevent any expanded future use of the records.

Patient Name: _____ DOB: _____

Signature: _____ Date: _____

Relationship (if patient is unable to sign): _____