DATE

Patient Information

Patient Name_____Guardian_____
(First) (Last)

Address: _____

_____
(City) (State) (Zip)

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Date of Birth: ____/_____/_____ Email: _____

Height_____ Weight_____ Are you Diabetic? YES / NO (Please Circle)

Please give details about your accident and/or tell us why you are here today:

_____

_____

PRIVACY DISCLOSURE STATEMENT: Please list any persons that we may discuss your care with:

Name:_____Relationship_____

Name:_____Relationship_____

What type of message may we leave on your voicemail: DETAILED or CALL BACK ONLY (please circle one)

Have you received same or similar brace or prosthesis from any provider in the past 5 years: Y or N

Insured's Name:_____ Relationship to Patient:_____

Employer Name and Address:

_____

_____

Injury or Illness result of accident? Yes or NO Date _____/_____/_____AUTO/WORK/OTHER

Primary Insurance: _____ Secondary Insurance: _____

Policy# Policy#

CONSENT AND AUTHORIZATION

I authorize J.C. Orthopedics, Inc. to bill my insurance/s on my behalf. I understand that I am responsible for any co-pay, co-insurances, or deductibles that apply. I understand that J.C. Orthopedics will attempt to verify benefits, but that is not a guarantee of payment. I understand that I am ultimately responsible for any balance owed. I also consent for treatment to be given to me that has been prescribed by my physician. I acknowledge that no guarantee has been made about the outcome of my treatment.

Sign:_____Date:_____

Fax Cover Sheet

J.C. ORTHOPEDICS, INC.

1680 HIGHWAY 88 WEST
BRICK, N.J. 08724
PHONE: (732) 458-7900 FAX: (732) 458-7902

Send to:	Regarding: ***MEDICAL RECORDS***
Date:	Fax Number:

TOTAL PAGES:____

In order to comply with Medicare standards, please forward medical records that pertain to the DMEPOS (listed below) prescribed.

On file, we need to have a copy of physician notes that state the medical necessity and expected outcomes. If there are radiological reports, please forward them as well.

DMEPOS ordered: _____ Date of Delivery_____

Ordering Physician: _____ Date of Rx_____

J.C. Orthopedic, Inc. will not receive payment from Medicare for the items that are ordered if you do not provide information from your medical records.

PATIENT RELEASE AUTHORIZATION:

I authorize the release of my medical records, which pertain to the DMEPOS being prescribed, to J.C. Orthopedic, Inc.

Beneficiary_____ ID # _____

Signature _____ Date_____