FOUNTAIN
ORTHOTICS • PROSTHETICS

1. PATIENT INFORMATION TODAY'S DATE: ____________________

REFERRAL DOCTOR: ______________________________ TELEPHONE#: (_______)__________________

PRIMARY CARE PHYSICIAN: ______________________________ TELEPHONE#: (_______)__________________

SEX: _____MALE _____FEMALE ***MARITAL STATUS:*** _____SINGLE _____MARRIED _____DIVORCED _____WIDOW

LAST NAME: ______________________ FIRST NAME: ______________________ MI: __________

DOB: ______/______/______ SOC SEC NO: ____________________ IS PATIENT DIABETIC? ____YES ____NO

STREET ADDRESS: ____________________ CITY: ____________________ST: ________ ZIP: ______________

HOME PHONE: (_______)______________ WORK PHONE: (_______)______________ CELL PHONE: (_______)______________

EMAIL: ____

EMPLOYER NAME: ______________________________ OCCUPATION: ____________________

EMPLOYER ADDRESS: ____________________ CITY: ____________________ST: ________ ZIP: ______________

REASON FOR VISIT? ______________________________ SIDE: RIGHT/ LEFT DATE OF INJURY: ______________

2. PLEASE COMPLETE THIS SECTION IF SOMEONE OTHER THAN PATIENT IS RESPONSIBLE FOR SERVICES

LAST NAME: ______________________ FIRST NAME: ______________________ MI: __________

STREET ADDRESS: ____________________ CITY: ____________________ST: ________ZIP: ______________

RELATIONSHIP TO PATIENT: ____________________ DOB: ______/______/______ SOC SEC NO: ______________

EMPLOYER NAME: ______________________________ OCCUPATION: ____________________

EMPLOYER ADDRESS: ____________________ CITY: ____________________ST: ________ ZIP: ______________

EMPLOYER PHONE: (_______)______________

3. WORKER'S COMPENSATION

WERE YOU INJURED ON THE JOB? _______YES_______NO POLICY#: ____________________

WORKER'S COMPENSATION CARRIER NAME: ______________________________ CLAIM#: ______________

WORKER'S COMP. ADDRESS: ______________________ CITY: ________________ST: _________ ZIP: ________

WORKER'S COMP. PHONE: ______________________________ ADJUSTER'S NAME: ____________________

4. ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I, the undersigned, have insurance with ______________________________ and assign directly to Fountain Orthotics and Prosthetics, Inc. all medical benefits, if any, otherwise payable to me for service rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Fountain Orthotics and Prosthetics, Inc. to access/obtain/release any medical information/records on file necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

5. **WAIVER FORM**

I, understand that my eligibility for coverage by ______________________________ cannot be determined at this time. I wish to receive medical services from Fountain Orthotics and Prosthetics. If it is determined that I am not eligible for coverage, I understand that I will be responsible for payment of all services provided.

______________________________/______________________________ ______________

Print Name **Signature of Insured/Guardian** **Date**

[ ] 16520 Harbor Blvd., Ste. G, **Fountain Valley** CA 92708 Ph: (714) 210-1298 Fax: (714) 210-1336
[ ] 2151 N. Harbor Blvd. Ste. 1200 **Fullerton** CA 92835 Ph: (714) 871-9960 Fax: (714) 871-9965
[ ] 3650 E. South St. Ste. 110B **Lakewood** CA 90712 Ph: (562) 206-8025 Fax: (562) 353-8060
[ ] 25982 Pala Dr., Ste. 100, **Mission Viejo** CA 92691 Ph: (949) 770-7331 Fax: (949) 770-8331
[ ] 351 Hospital Road, Ste. 106, **Newport Beach** CA 92663 Ph: (949) 722-7101 Fax: (949) 722-7120
[ ] 623 N. Main Street, **Orange** CA 92868 Ph: (714) 937-1998 Fax: (714) 937-1994
[ ] 14450 Hoover St., **Westminster** CA 92683 Ph: (714) 373-9888 Fax: (714) 373-9890

MEDICAL RECORDS RELEASE FORM

I authorize the release of my confidential health information by releasing a copy of my medical records to

Fountain Orthotics & Prosthetics.

Patient Name :_________________________ **Date of Birth**:______________

Signature:____________________________ **Date**:____________________

For Office Use Only

Fountain Orthotics & Prosthetics is requesting the following documents:

☐ Most recent notes

☐ Notes from office visit on ________________

☐ Diabetic follow-up, including labs

☐ Other ____

Notes ____

____

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

This form will be retained in your medical record

By my signature below I, ________________________________, acknowledge that I received a copy of the Notice of Privacy Practices for ***Fountain Orthotics & Prosthetics, Inc.***

I hereby designate the following individual(s) to receive communications from Fountain Orthotics & Prosthetics, Inc. that may include health information about me:
Name:________________________ Relationship:___________ Phone:__________________

If this acknowledgement is signed by a personal representative, complete the following:

Personal Representative's name: ____

Relationship to Patient: ____

I authorize *Fountain Orthotics and Prosthetics, Inc.* to leave voice mail messages concerning my health information at the following number: Phone: (   )_____________

____ ___________________

Patient Name (Printed) **Date**

Signature

*This signature will be used to verify identity with regards to PHI (Protected Health Information)

For Office Use Only

I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign
☐ Communications barriers prohibited obtaining the acknowledgement
☐ An emergency situation prevented us from obtaining acknowledgement
☐ Other (Please Specify)

____

____

_________________________________ _________________________________
Employee Name Date

[ ] 16520 Harbor Blvd., Ste. G, **Fountain Valley** CA 92708 Ph: (714) 210-1298 Fax: (714) 210-1336
[ ] 2151 N. Harbor Blvd. Ste. 1200 **Fullerton** CA 92835 Ph: (714) 871-9960 Fax: (714) 871-9965
[ ] 3650 E. South St. Ste. 110B **Lakewood** CA 90712 Ph: (562) 206-8025 Fax: (562) 353-8060
[ ] 25982 Pala Dr., Ste. 100, **Mission Viejo** CA 92691 Ph: (949) 770-7331 Fax: (949) 770-8331
[ ] 351 Hospital Road, Ste. 106, **Newport Beach** CA 92663 Ph: (949) 722-7101 Fax: (949) 722-7120
[ ] 623 N. Main Street, **Orange** CA 92868 Ph: (714) 937-1998 Fax: (714) 937-1994
[ ] 14450 Hoover St., **Westminster** CA 92683 Ph: (714) 373-9888 Fax: (714) 373-9890

Insurance Information

Fountain Orthotics and Prosthetics is requesting that you provide **ALL** insurance information and insurance cards at the time of service.

It is your responsibility to provide complete insurance information so that Fountain Orthotics and Prosthetics may bill your insurance(s) on your behalf. Failure to provide this information may result in you, and /or the member, being financially responsible for any and all outstanding balance(s) due.

Fountain Orthotics and Prosthetics is not responsible for any failure on your part to provide any and all correct and current insurance information. It is unlawful for Fountain Orthotics and Prosthetics to "back date" your date of service; therefore, it is imperative that you provide all necessary information no later than by your final fitting appointment.

Please understand that insurance companies base its decisions upon the dates of service as well as timely filing, so it is imperative that all insurance information is correct, current, up to date and complete. Thank you for your cooperation and assistance.

I fully understand and acknowledge the term and provisions regarding my responsibility as stated above.

________________________________ ________________

Patient/Legal Guardian Signature **Date**

Photo Release

Patient Name: ____________________ DOB: ___________

Parent or Legal Guardian: ___________________________________

I consent to have MY (OR my child or an individual to whom I provide guardianship) image to be taken by the staff at Fountain Orthotics and Prosthetics as described below.

I understand that my (or child or an individual to whom I provide guardianship) photographs, videotapes, digital, and other images may be recorded to document and assist with my care and the payment of my bill (or child or an individual to whom I provide guardianship). These images may be used to assist in the education of students and residents within the institution. I understand that the Fountain Orthotics and Prosthetics will own these images, but that I will be allowed access to view them or to obtain copies of them at a reasonable cost. Other than for treatment, education, and payment purposes, images that identify me (or child or an individual to whom I provide guardianship) will be released and/or used outside the organization only upon written authorization from me or the patient representative.

If the images are to be taken for any purpose other than for treatment, education, or payment purposes, the purpose(s) must be stated: ____
____

I may revoke or withdraw this consent at any time. Such withdrawal of consent must be made in writing. Withdrawal of consent does not affect any information disclosed prior to the written notice of withdrawal.

I release and hold harmless Fountain Orthotics and Prosthetics and its staff and employees from any and all claims or causes of action that I may have of any nature whatsoever, which may in any manner result from the use of the photograph or other image.

By signing below, I am indicating that I have read and understand the "Consent for Photography" form. I am either the patient or have the authority to give consent for the patient. My questions regarding this consent have been answered.

_____________________________________ _____________________________
Patient or Patient Representative Signature Date

_____________________________________ _____________________________
If Patient Representative, Relationship to Patient Printed Name

Acknowledgement of Financial Responsibility Form

Provider:
Fountain Orthotics & Prosthetics

Member Acknowledgment of
Financial Responsibility

Member Financial Arrangement

This form is used for health insurance members who wish to receive healthcare services from Fountain Orthotics & Prosthetics that may not be covered by your health insurance benefit plan.

Your signature on this form acknowledges that you agree to bear full financial responsibility for all services provided as listed below:

* The services that are not covered under your health insurance benefit plan, or,
* the services that have not been otherwise approved for payment by your health insurance.
* **INSURANCE IS NOT A GUARANTEE OF PAYMENT**

Disclaimer

Insurance coverage is estimated – your actual indemnity may be more or less. You, the patient, are responsible for all amounts not covered by your insurance carrier. Year-To-Date used benefits and remaining deductible amounts are not affected until the procedure is completed and therefore are not used in this determination of benefits.

Fountain O & P charges two percent (2%) charge for all balances not paid within three (3) months.

____
Member or Member's
Legal Representative Name (Please Print)

____
Member or Member's
Legal Representative Signature

Date: ____________________

FOR QUESTIONS, CONTACT YOUR HEALTH INSURANCE MEMBER SERVICES AT THE NUMBER LOCATED ON YOUR HEALTH INSURANCE CARD.