FOUNTAIN
ORTHOTICS•PROSTHETICS

1. INFORMACION DEL PACIENTE

FECHA:_____________________

DOCTOR DE REFERENCIA: ____ #TELEFONO:(________) _____________________

DOCTOR PRIMARIO: ____ #TELEFONO:(________) _____________________

SEXO: ____ MASCULINO ____ FEMENINO ***ESTADO MATRIMONIAL:*** ____SOLTERO ____ CASADO ____ DIVORCIADO ____ VIUDO

APELLIDO: _________________________________ NOMBRE: ____________________________ INCIAL DE MEDIO NOMBRE: _________

FECHA DE NACIMIENTO: ______/______/______ SEGURO SOCIAL: ______________________ ES DIABETICO EL PACIENTE? ____SI ____NO

DIRECCION: _______________________________ CIUDAD: __________________________ ESTADO: _______ CODIGO POSTAL: ________

#TELEFONO CASA: (_______) ________________ #TRABAJO: (________) ___________________ #CELULAR: (________) ________________

CORREO ELECTRONICO:____

EMPLEADOR: ____ OCCUPACION: ____

DIRECCION DE EMPLEO: ____________________________CIUDAD: ______________________ESTADO: _____ CODIGO POSTAL: _________

RAZON POR SU VISITA? ________________________________ LADO: DERECHA/IZQUIERDA FECHA DE LASTIMADURA: ___________

2. POR FAVOR DE COMPLETAR ESTA SECCION SI OTRA PERSONA APARTE DEL PACIENTE ES RESPONSABLE POR LOS SERVICIOS

APELLIDO: _________________________________ NOMBRE: ____________________________ INCIAL DE MEDIO NOMBRE: _________

DIRECCION: _______________________________ CIUDAD: __________________________ ESTADO: _______ CODIGO POSTAL: ________

RELACION AL PACIENTE: __________________FECHA DE NACIMIENTO: ______/______/_____SEGURO SOCIAL: ______________________

EMPLEADOR: ____ OCCUPACION: ____

DIRECCION DE EMPLEO: ____________________________CIUDAD: ______________________ESTADO: _____ CODIGO POSTAL: _________

TELEFONO DEL EMPLEADOR: (_____)__________________

3. INFORMACION DE ASEGUARANZA AL TRABAJADOR (COMPENSACION DEL TRABAJO)

FUE LASTIMADO EN EL TRABAJO? ____SI____NO # DE POLIZA: ____

ASEGURANZA RESPONSABLE DE COMPENSACION DEL TRABAJO: ____

DE RECLAMO: ___________________________________

DIRECCION DE COMPENSACION DEL TRABAJO: ____

CIUDAD: ____ ESTADO: ___________CODIGO POSTAL: ________________

TELEFONO DE COMPENSACION DE TRABAJO: (______)__________________NOMBRE DEL AJUSTADOR:_____________________________

4. ASIGNACION DE BENEFICIOS Y PERMISO DE DAR MI INFORMACION

Por medio de mi firma, yo verifico que tengo aseguranza con _________________________________y asigno directamente a Fountain Orthotics and Prosthetics, Inc. todos los benificios medicos, si los hay, que de otra manera serian pagables a mi por servicios recibidos. Entiendo que soy financieramente responsable por todos los cargos asi sean o no pagados por mi aseguranza. Yo por este medio autorizo a Fountain Orthotics and Prosthetics, Inc. acceso a/obtener cualquier informacion necesaria para asegurar el pago de los beneficios. Yo autorizo el uso de esta firma en todas las submisiones a mi aseguranza.

5. FORMA DE RENUNCIA

Yo entiendo que mi elegibilidad de cobertura por _____________________________________no puede ser determinada en este momento. Yo deseo recibir servicios medicos de Fountain Orthotics and Prosthetics, Inc. si es determinado que no soy elegible de cobertura, entiendo que sere responsable de pago de todo servicio proveido.

____/____ ______________________

Nombre **Firma** **Fecha**

[ ] 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

INFORMACION SOBRE SEGURO

FOUNTAIN ORTHOTICS AND PROSTHETICS, SOLICITA QUE USTED PROPORCIONE TODAS SUS TARJETAS DE SEGURO, CON TODA LA INFORMACION REQUERIDA AL MOMENTO DEL SERVICIO.

ES SU RESPONSABILIDAD DE PROPORCIONAR INFORMACION DE SEGURO PARA QUE FOUNTAIN ORTHOTICS AND PROSTHETICS PUEDA ENVIAR EL COBRO A SU SEGURO EN SU NOMBRE. SI LA INFORMACION REQUERIDA NO ES PROPORCIONADA COMPLETA TENDRA COMO RESULTADO QUE USTED (O) EL MIEMBRO SEA RESPONSABLE DE CUALQUIER BALANCE DEBIDO.

FOUNTAIN ORTHOTICS AND PROSTHETICS NO ES RESPONSIBLE DE NINGUN FRACASO EN SU PARTE, PARA PROPORCIONAR CUALQUIER Y TODA INFORMACION CORRECTA SOBRE SU SEGURO. ES ILEGAL QUE FOUNTAIN ORTHOTICS AND PROSTHETICS CAMBIA LA FECHA DE SU SERVICIO, POR LO TANTO SERA IMPRESCINDIBLE QUE USTED PROPORCIONE TODA INFORMACION NECESARIA NO POSTERIOR QUE POR SU CITA FINAL.

POR FAVOR COMPRENDA QUE LAS COMPANIAS DE SEGUROS BASAN SUS DECISIONES, EN LAS FECHAS DE SERVICIO AL IGUAL QUE EN SOMETER LAS COBROS EN EL TIEMPO AUTORIZADO. ES MUY IMPORTANTE QUE TODO INFORMACION SOBRE SU SEGURO SEA CORRECTA, ESTE AL CORRIENTE, Y COMPLETA. GRACIAS POR SU COOPERACION Y ASSITENCIA.

COMPRENDO COMPLETAMENTE Y RECONOZCO LOS TERMINOS Y PROVISIONES CON RESPECTO A MI RESPONSABILIDAD COMO INDICARON ARRIBA.

______________________________ _______________

Firma de Paciente/Tutor **Fecha**

[ ] 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
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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

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

FOUNTAIN
ORTHOTICS • PROSTHETICS

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)

________________________________ **Date**: ____________________
Member or Member's
Legal Representative Signature

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