Advanced Prosthetics & Orthotics
5602 Waters Ave.~Savannah, GA
912-629-7374/912-226-7644 Fax

R. L. "Buddy" Grayson CPO/LPO PH.D

REGISTRATION FORM

Section I: Patient Information

Weight_____

Name: _____ I Prefer to be called: _____
Address: _____ City: _____ State: _____ Zip_____
Phone (_____) _____ Work Phone (_____) _____ Cell Phone (_____) _____
The best time to contact me is: _____ ☐ A.M. ☐ P.M. On my ☐ Home phone ☐ Work phone ☐ Cell
Date of Birth: _____ Social Security Number: _____ Email_____
Spouse or Parent's Name: _____ Employer_____ Work Phone_____
Whom may we thank for referring you? _____
Person to contact in case of emergency_____ Phone_____

Section II Medical Information

Primary Care Physician: _____ Referring Physician: _____
Therapy Facility: _____ PT/OT Name: _____
Address: _____ City: _____ Phone: (____) _____

Section III Insurance Information

Name of Insured_____ DOB_____ Relationship to Patient _____
SSN#:_____ Name of Employer: _____ Work Phone: (____) _____
Address of Employer: _____ City_____ State:_____ Zip _____
Insurance Company_____ Grp #_____ ID#_____
Ins Co Address: _____ INS Co. Phone:
_____

---------- DO YOU HAVE ANY ADDTIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING ----------

Name of Insured_____ DOB_____ Relationship To Patient _____
SSN#:_____ Name of Employer: _____ Work Phone: (____) _____
Address of Employer: _____ City_____ State:_____ Zip _____
Insurance Company_____ Grp #_____ ID#_____
Ins Co Address: _____ INS Co. Phone: _____

Patient Signature: _____ Date: _____

Parent or Guardian Signature: _____

Advanced Prosthetics & Orthotics

_____

(Patient's Printed Name)

Assignment of Benefits/Authorization to Release Information

I request that payment of authorized Medicare, Medicaid, or private insurance benefits be made to Advanced Prosthetics and Orthotics LLC, for any covered services furnished by Advanced Prosthetics and Orthotics. I agree to pay Advanced Prosthetics & Orthotics LLC the deductible and/or coinsurance on my claim.

I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents, Champus/TRICARE and its agents, or to any private insurance company any information needed to determine these benefits or the benefits payable for related services.

I further certify that the information provided by me is true, accurate and complete.

I understand and agree that I am responsible for the following expenses: any service my insurance plan deems "non-covered", all coinsurance and/or co-payment amounts, all deductibles, any amount that exceeds benefit limits under my insurance plan and any amount my insurance plan deems not covered because I was not insured on the date of service.

I acknowledge having received 1) a copy of Advanced Prosthetics and Orthotics LLC,'s Notice of Privacy Practices (NPP), 2) Main Patient Brochure which includes: Welcome Letter, Medicare Supplier Standards, Mission Statement, Bill of Rights, Warranty & Patient Responsibilities and 3) Advanced Prosthetics and Orthotics LLC, Financial Policy.

_____ _____

Patient or Responsible Party Signature Date

If Responsible Party, please complete below:

_____

Printed Name

_____

Address

Relationship to Patient: _____

Reason for Patients' Inability to Sign: _____

For Notice of Privacy Practices only, describe the Responsible Party's authority to act on behalf of the patient:_____