PATIENT REGISTRATION FORM

Patient's Last Name: **First Name**: **Middle Initial**:

Date Of Birth: / / **Gender**: M ___ F ___ **Preferred Pronouns:**

Email: **Current Employment Status**: Full-Time

Driver's License: **Marital Status**: Single

Home Phone: **Cell Phone**: **Work Phone**:

Home Address:

Mailing Address: (*if different than home address*):

*****OPTIONAL INFO TO COMPLETE:***

Race/Ethnicity Selection | Hispanic or Latino? | Education Level | Armed Forces Service

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Emergency Contact: **Relationship**: **Phone**:

Prescribing Doctor: **Phone**: **Fax**:

Primary Care Doctor: **Phone**: **Fax**:

How did you hear about us?:

PRIMARY INSURANCE

Insurance Company Name:

ID #: **Group #**: **Subscriber's Employer**:

Relationship to Subscriber: Self___ Spouse___ Dependent ___ Other___ *****If SELF is Checked, SKIP to next question***

Subscriber's Name: Subscriber's Date of Birth:

Subscriber's Gender: M ___ F___ Subscriber's SSN: Phone:

Address (if different):

SECONDARY INSURANCE

Insurance Company Name:

ID #: **Group #**: **Subscriber's Employer**:

Relationship to Subscriber: Self___ Spouse___ Dependent ___ Other___

Subscriber's Name: Subscriber's Date of Birth:

Subscriber's Gender: M ___ F___ Subscriber's SSN: Phone:

Address (if different):

WORKERS COMPENSATION: Yes ___ No ___ **Claim #**: **Injury Date**:

Carrier Name: **Claims Phone Number**:

Claims Address:

Adjuster's Name: **Phone:** **Email:**

Attorney's Name: **Phone:** **Email:**

Form Completed By: **Relationship**: **Date**:

PATIENT MEDICAL PROFILE/HISTORY

Name: _____ **Date:** _____

Height: _____ **Weight:** _____ lbs **Shoe Size:** **Side Affected:** ☐ RIGHT ☐ LEFT ☐ BOTH

Tobacco Use?: ☐ Currently ☐ Quit ☐ Never **Type**: _____

Falls in last 6 Mo? ☐ YES ☐ NO If Yes: **How many**? _____ **Were you hospitalized**? ☐ YES ☐ NO

Hospital, ER, or Urgent Care in last 6 Mo? ☐ YES ☐ NO **Details**: _____

General Health: ☐ POOR ☐ FAIR ☐ GOOD ☐ EXCELLENT

Your Activity Level: ☐ SEDENTARY ☐ LIMITED ACTIVITY ☐ ACTIVE ☐ VERY ACTIVE

PLEASE CHECK ALL THAT APPLY:

☐ Accident from Employment Date of Accident: _____

☐ Auto Accident State Accident Occurred: _____

☐ Other Type of Accident County Accident Occurred: _____

☐ Condition Since Birth If Accident Describe: _____

Have you received a device in the past 5 years? ☐ YES ☐ NO **If so, please provide details:**

List any other conditions that you feel might affect your treatment:

List Medications:

Amputations? ☐ YES ☐ NO **Level**: **Date of Amputation:**
Reason:

Allergies? ☐ YES ☐ NO **List:**

Pain Medication? ☐ NO ☐ YES
List Pain Medication, Dosage, and Frequency

Major Surgeries? ☐ NO ☐ YES
List Surgery & Year:

DO YOU HAVE OR HAVE YOU HAD THE FOLLOWING?

- ☐ Alzheimers or Dementia
- ☐ Anxiety
- ☐ Asthma
- ☐ Brain Injury/TBI
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Hearing Loss
- ☐ Heart Problems
- ☐ Hepatitis Circle: A B C
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Infections
- ☐ Intestinal Problems
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Migraines
- ☐ MRSA
- ☐ Neurological Problems
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Parkinson's Disease
- ☐ Pulmonary Disease (TB)
- ☐ Rheumatoid Arthritis
- ☐ Seizure Disorders
- ☐ Skin Problems
- ☐ Stomach Problems
- ☐ Stroke/TIA/CVA
- ☐ Vascular Disease
- ☐ Vision Problems

OTHER CONDITIONS

- ☐ Alcoholism
- ☐ Currently Pregnant
- ☐ Incontinence
- ☐ Joint Replacement
- ☐ Pacemaker
- ☐ Scoliosis

Surgeon's Name:

Specialty (Orthopedics, Neurology, Plastic, Other):

Group Practice Name and Location:

Phone: Fax: Last Seen:

Physical or Occupational Therapist:

Group Practice Name and Location:

Phone: Fax: Last Seen:

List any changes/updates to your medical history:

Last Updated by Patient On:

Prosthetic & Orthotic Associates, Inc.
Handspring Clinical Services

Patient's Name: _____

Acknowledged Receipt of Notice of Privacy Practices

I, the undersigned, certify that I have received a copy of Prosthetic & Orthotic Associates, Inc./Handspring Clinical Services' Notice of Privacy Practices. The Notice describes the types of use and disclosure of my protected health information that might occur in my treatment, payment of my claim, or in the performance of POA/Handspring's health care operations. The Notice of Privacy Practices also describes my rights and POA/Handspring's duties with respect to my protected health information. The Notice of Privacy Practices is posted in each perspective office, and we reserve the right to change the privacy practices that are described within. I may obtain a revised Notice of Privacy Practices by requesting a copy be sent in the mail or asking for one at the time of my appointment.

Initials _____

OPTIONAL

I give my permission to leave a ***detailed message*** at the following phone number(s):

Home: (_____)_____ Cell: (_____)_____ Other: (_____)_____ Specify Type: _____

I give my permission to receive ***text messages*** at the following phone number(s):

Cell: (_____)_____ *(Relationship: _____)* Cell: (_____)_____ *(Relationship: _____)*

I understand that text message communications may be unsecured and therefore the potential that the communication could be read by a third party. I understand my mobile provider's standard rates for sending and receiving text messages will apply.

Initials _____

Family & Friends Release

The name(s) listed below are family members or friends to whom I wish to grant access to my personal health care information (PHI). I will rely on the professional judgement of my provider and his/her designee to share such information, as they deem necessary. I understand that information is limited to verbal discussions and that no paper copies of my PHI information will be provided without additional consent to release any sensitive information

Name: _____ Relationship: _____ Phone: _____ Home? ☐ Cell? ☐

Name: _____ Relationship: _____ Phone: _____ Home? ☐ Cell? ☐

These consents will be considered valid until such time that I revoke them, and I reserve the right to revoke them at any time. It will be my responsibility to keep this information up to date.

Initials _____

Medicare DMEPOS Supplier Standards (*For Beneficiaries only*)

I have been provided a copy of the Medicare DMEPOS Supplier Standards.

Initials _____

Acknowledged Receipt of Patient Financial Policy

I certify that the insurance coverage listed on the registration form is accurate to the best of my knowledge and have received a copy of POA/Handspring's financial policy. I understand that I am financially responsible for any amount not covered by my insurance contract.

Initials _____

Billing Authorization

I, the undersigned, authorize the release of any medical or other information necessary to process the claim. I request payment of commercial and/or government health insurance benefits be assigned to POA/Handspring. I authorize the use of this signature on all my insurance claim submissions.

_____ _____

Patient /Legal Guardian/Authorized Person's Signature Date

_____ _____

Printed Name of Guardian/ Authorized Person Relationship to Patient / Description of Authority

POA / HANDSPRING PATIENT FINANCIAL POLICY

We are committed to building a successful relationship with you and your family. As such, your clear understanding of our Patient Financial Policy is important to our professional relationship and payment for services is a part of that relationship. It is your responsibility to notify our office of any patient or insurance information changes.

Coinsurance & Deductible
All coinsurance amounts and past due balances, are due at the time services are rendered, unless previous arrangements have been made with administrative staff. We accept cash, check or credit cards. No post-dated checks will be accepted.

Insurance Claims
Insurance is a contract between you and your insurance company, and we bill them as a courtesy to you. To bill properly, we require that you disclose all insurance information including primary and secondary insurance, as well as any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network with your insurance company, and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

To ensure a smooth claims process, please avoid making any changes to your insurance coverage during the fitting and fabrication of your device. The date of service for your claim will be the date your device is delivered.

If your insurance plan is one with which we are not a participating provider, you will be responsible for payment in full at the time of delivery unless other arrangements have been made with administrative staff. As a courtesy, we will file your initial insurance claim.

Minors
The parent(s) or guardian(s) is/are responsible for full payment and will receive the billing statements. A signed release to treat may be required for unaccompanied minors.

Motor Vehicle Accident (MVA) & Third-Party Billing
Since our relationship is with you and not with the third-party liability insurance (auto, homeowner, etc.), we will not be submitting a claim on your behalf. It is your responsibility to seek reimbursement from the liability insurance. However, at your request, we will submit a claim to your primary health insurance carrier. You may receive an accident questionnaire from your health insurance to be completed by you. If the questionnaire is not returned to your health insurance company and/or we receive a denial on your claim, you will be responsible for payment in full.

Outstanding Balance Policy
Our office policy requires that all patients receive routine statements. If payment is not received within a reasonable time, we will attempt to arrange a payment plan. If no resolution is reached, the account may be referred to a collection agency. This could result in discharge from our practice. The person responsible for the account will be liable for all collection costs, including attorney fees and court costs.

POA / HANDSPRING PATIENT FINANCIAL POLICY

Refunds
We do our best to estimate your deductible and coinsurance before you receive your device. However, there may be discrepancies during the processing of our claim. Any overpayment will be credited to your account. Please contact our billing department if a refund is preferred.

When a custom fabricated device is prescribed by the physician and made to fit you, it cannot be returned for credit or refund. Prescribed prefabricated items cannot be returned for credit or refund due to hygienic concerns.

Returned Checks
The charge for a returned check is $35 payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash-only basis following any returned check.

Self-pay Accounts
Self-pay accounts include when patients have no insurance coverage, patients are covered by insurance plans in which the office does not participate and liability cases. We do not accept attorney letters or contingency payments. Extended payment arrangements may be considered on an individual basis. Please ask the office administrative staff to discuss a mutually agreeable payment plan. It is never our intention to cause hardship to our patients, only to provide them with the best care possible and the least amount of stress.

Workers' Compensation
It is the patient's responsibility to provide our office staff with claims adjuster and/or attorney contact information regarding a workers' compensation claim. If the claim is denied by the workers' compensation insurance carrier, it then becomes the patient's financial responsibility. At your request, we will submit the claim to your primary medical insurance carrier with a copy of the workers' compensation insurance denial. If your primary medical insurance carrier's claim is denied, you will be responsible for payment in full.

This financial policy helps the office provide quality care to our valued patients. If you have any questions or need clarification of any of the above policies, please feel free to contact us at POA/Handspring, 4 Riverside Drive, Middletown, NY 10941 or (845) 956-0001

Prosthetic & Orthotic Associates, Inc.
Handspring Clinical Services

Handspring

PRIVACY POLICY

This Privacy Policy describes Prosthetic & Orthotic Associates, Inc.'s (POA's) and Handspring Clinical Services' (Handspring's) policies and procedures on the collection, use and disclosure of your information when you use our service and tells you about your privacy rights and how the law protects you.
We use your personal data to provide and improve the Service. By using the Service, you agree to the collection and use of information in accordance with this Privacy Policy.

POA/Handspring is committed to safeguarding the privacy of our users. We want to assure you that we do not share your personal information with third parties. This privacy policy outlines how we collect, use, and protect the information you provide to us.

INFORMATION COLLECTION:
We collect only the information necessary to provide and improve our services. This may include your name, email address and phone number. We do not sell, rent, or share this information with any third parties.

HOW WE USE YOUR INFORMATION:
The information collected is used solely for communicating with you as the intended party. We do not share your information with external parties for marketing or any other purposes.

We may use personal data for the following purposes:

- To provide and maintain our service, including to monitor the usage of our service.
- To manage your Account: to manage your registration as a user of the Service. The Personal Data you provide can give you access to different functionalities of the Service that are available to you as a registered user.
- For the performance of a contract: the development, compliance and undertaking of the purchase contract for the products, items or services you have purchased or of any other contract with us through the Service.
- To contact You: To contact you by email, telephone calls, SMS, or other equivalent forms of electronic communication, such as a mobile application's push notifications regarding updates or informative communications related to the functionalities, products or contracted services, including the security updates, when necessary or reasonable for their implementation.
- To provide you with news, special offers and general information about other goods, services and events which we offer that are similar to those that you have already purchased or enquired about unless you have opted not to receive such information.
- To manage your requests: To attend and manage your requests to us.

All messages you send through the Service, whether to us or other users, are stored on our servers. POA/Handspring employs servers and services owned by third parties to retain these messages.

DISCLOSURE OF YOUR INFORMATION
POA/Handspring does not share any client data with third parties for marketing, promotional purposes, or any other purposes.

Your personal information is kept confidential and is not disclosed to any outside organizations, except as required by law or with your explicit consent. We may disclose your personal Information under the following limited circumstances:

- We have obtained your consent.
- We need to enforce our Terms of Service.
- We share information with partners or affiliates that have signed non-disclosure agreements with us only to provide you with a specific service.
- We may provide such information to a company controlled by or under common control with POA/Handspring any purpose allowed by this Policy.
- We respond to subpoenas, court orders, or legal processes, or to establish or exercise our legal rights, or the legal rights of others, or defend against legal claims.
- When we believe it is necessary to disclose Personal Information to investigate, prevent, or take action regarding illegal activities, suspected fraud, potential threats to anyone's physical safety, violations of POA/Handspring Terms of Service, or as otherwise required by law.
- We transfer Personal Information about you if POA/Handspring or its assets are acquired by or merged with another company.

We may share aggregated, non-identifiable information with others without further notice to you, such as the total number of people who used the Service in a specific month or the total number of messages sent during a particular period.

INTERNATIONAL DATA TRANSFERS

Your Personal Information may be transferred to and processed in locations outside of your state, province, country, or other governmental jurisdiction where the data protection laws may differ from those in your jurisdiction. We take steps to ensure that your data is handled securely and in line with this Policy, regardless of where it is processed.

DATA RETENTION

We retain your Personal Information only as long as necessary to fulfill the purposes outlined in this Policy unless a longer retention period is required or permitted by law. We will also retain and use your Personal Information as necessary to comply with legal obligations, resolve disputes, and enforce our agreements.

COOKIES AND TRACKING TECHNOLOGIES

Our Service may use cookies and similar tracking technologies to enhance your experience. Cookies are small text files placed on your device to collect information about your activity on the Service. You can control the use of cookies through your browser settings, but disabling cookies may limit your ability to use certain features of the page or Service.

YOUR CHOICES:

You have the right to access, correct, or delete your information. If you have any concerns or questions about your data, please contact us by Phone: 845-956-0001; Fax: 845-344-6829; Email: info@poaprosthetics.com; Mail: 4 Riverside Drive, Middletown, NY 10940

POLICIES CHANGES:

We may update our privacy policy from time to time. Any changes will be communicated to you, and your continued use of our services implies your acceptance of the updated policy. By using our services, you agree to the terms outlined in this privacy policy.

Last updated: 10/10/2024