CARE CRAFTERS
PROSTHETICS & ORTHOTICS, INC.

PATIENT REGISTRATION *ID# :*_____(office use only) Initial:_____

NAME: _____

(first) *(last)*

HOME ADDRESS:_____ _____

(street) *(city)* *(state)* *(zip)*

CELL PHONE:_____ E-MAIL:_____

HOME PHONE:_____WORK PHONE:_____

DATE OF BIRTH:_____SEX:_____MARITAL STATUS: (married) (single) (other)

HEIGHT:_____WEIGHT:_____DIABETIC?_____

EMERGENCY CONTACT:_____PHONE:_____

REASON FOR VISIT:_____ DATE OF ONSET:_____

DO YOU HAVE ANY OTHER HEALTH ISSUES WE NEED TO KNOW ABOUT?_____

PRESCRIBING DR:_____PHONE:_____FAX:_____

PRIMARY DR:_____PHONE:_____FAX:_____

PHYSICAL THERAPIST:_____ PHONE:_____FAX:_____

EMPLOYER:_____OCCUPATION:_____

REFERRED BY:_____

PRIMARY INSURANCE CO:_____

IS THIS AN HMO? PPO?_____IS PRE-AUTHORIZATION NEEDED?_____

ADDRESS:_____

PHONE:_____POLICY/CASE/PO#_____

INSURED:_____INSURED DOB:_____

SECONDARY INSURANCE CO:_____

IS THIS AN HMO? PPO?_____IS PRE-AUTHORIZATION NEEDED?_____

ADDRESS:_____

PHONE:_____POLICY/CASE/PO#_____

INSURED:_____INSURED DOB:_____

I authorize Care Crafters to release any information acquired in the course of medical examination or treatment for insurance claim filing. I request that all insurance payments be made out to Care Crafters.

SIGNATURE_____DATE:_____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby consent to Care Crafters Prosthetics & Orthotics, Inc. using and disclosing my protected health information (PHI) to carry out treatment, payment and healthcare operations (TPO). I hereby acknowledge that I have had the right to review Care Crafters Prosthetics & Orthotics, Inc.'s Privacy Policy prior to signing this consent, which provided me a more complete description of potential uses and disclosures of my PHI. I am aware that Care Crafters Prosthetics & Orthotics, Inc. reserves the right to revise its Privacy Policy at anytime. I am also aware that a revised Privacy Policy may be obtained by my forwarding a written request for same to Care Crafters Prosthetics & Orthotics, Inc.

Consent to Calls/Mail/Email

I hereby consent to Care Crafters Prosthetics & Orthotics, Inc. calling my home, cell phone or other designated location and leaving a message on my voicemail or in-person in reference to any items that assist Care Crafters Prosthetics & Orthotics, Inc. in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results and other matters incident to my treatment.

I hereby consent to Care Crafters Prosthetics & Orthotics, Inc. mailing to my home or other designated location any items that assist Care Crafters Prosthetics & Orthotics, Inc. in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

I hereby consent to Care Crafters Prosthetics & Orthotics, Inc. e-mailing me any items or communications that assist Care Crafters Prosthetics & Orthotics, Inc. in carrying out TPO, such as appointment reminder cards and patient statements.

I understand that I have the right to request that Care Crafters Prosthetics & Orthotics, Inc. restrict how it uses or discloses my PHI to carry out TPO. However, Care Crafters Prosthetics & Orthotics, Inc. is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Care Crafters Prosthetics & Orthotics, Inc.'s use and disclosure of my PHI as specified in the Privacy Policy and this Patient Consent for Use and Disclosure of Protected Health Information.

I understand that I may revoke my consent in writing, except to the extent that Care Crafters Prosthetics & Orthotics, Inc. has already made disclosures in reliance upon my prior consent. If I do not sign this consent, I understand that Care Crafters Prosthetics & Orthotics, Inc. may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Patient's Name Date

_____ _____
Phone Number(s) (Cell/Home/Work) Email Address

To Whom It May Concern:

Please accept this letter as my authorization to release my medical records to Care Crafters Prosthetics & Orthotics, Inc. located at 95 New Clarkstown Road in Nanuet, New York. Telephone: 845-426-6900 – Fax: 845-426-6926.

Sincerely,

Name: _____

Address: _____

_____

Birth Date: _____

Telephone: _____

Signature: _____

Date: _____

I understand I have the right to revoke this agreement, in writing, at any time.

*If signed by a Personal Representative, the following must be included:

Name of Personal Representative: _____

_____
Description of Personal Representative's authority to act on behalf of Patient