

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____ Preferred Name: _____

Date of Birth:	Gender: (check one) Male Female	SSN:	E-mail Address:	
Mailing Address	City	ST	Zip Code	Primary Language:
Marital Status	Home Phone:	Ok to Leave Message: Yes No	Cell Phone:	Ok to Leave Message: Yes No
How Did You Hear About Us? Doctor/Hospital Patient Friend/Family Internet			Other: _____	
How may we contact you? Phone: Yes No Email: Yes No				
Referring Doctor:		Primary Care Doctor:		

RESPONSIBLE PARTY INFORMATION (PARENT/GUARDIAN)

Guarantor Name:	Address:	Phone Number:	Ok to Leave Message: Yes No
E-Mail Address:	Date of Birth:	Relationship to Patient:	

EMERGENCY CONTACT / WHO WE CAN COMMUNICATE WITH REGARDING APPOINTMENTS AND MEDICAL INFO.

Name (First, Last):	Relationship to patient:	Phone:	OK to Leave a Message:
			Yes No
			Yes No

INSURANCE INFORMATION *PLEASE PROVIDE YOUR INSURANCE CARD

Please Check Box If SELF Pay

Worker's Comp Case: **Y** **N**

1. Primary Insurance Company		ID #:		
Subscriber Name:	Relationship to Patient:	Phone #:	DOB:	SSN:
2. Secondary Insurance Company		ID #:		
Subscriber Name:	Relationship to Patient:	Phone #:	DOB:	SSN:

Originated: February 17, 2020

PHYSICAL THERAPY INFORMATION

Yes No Are you currently or have you recently worked with a physical and/or occupational therapist?
If yes, please answer the following: **Physical Therapist** **Occupational Therapist**
Name of Therapist: _____ **How often?** _____

ADDITIONAL INFORMATION

Yes No Have you received a like or similar device within the last 5 years from either
[company name] or any other provider?

Yes No Are you currently residing in a nursing home, assisted living or group home?
If yes, Name of Facility: _____
Phone Number: _____

Yes No Have you received a motorized wheelchair within the last 5 years?

Payment and Policy Agreement

Your insurance policy is a contract between you and your insurance company to help you meet medical expenses. Because benefits can vary greatly, it is not possible for Sunshine P+O to provide services on the basis that your insurance company will pay all charges.

Sunshine P+O can in no way guarantee coverage. Benefits are determined by your insurance plan at the time your claim is processed. All benefit calculations are only an estimate, based on information obtained from your insurance company. The actual Total Patient's Responsibility may be different than what was previously estimated by Sunshine P+O.

To prevent any misunderstanding about medical insurance, we wish to point out that: (1) Payment for all medical services furnished are the responsibility of the patient; (2) Deductibles, co-payments, and/or other patient responsibility amounts are due at the time services are rendered; (3) For deductibles, co-insurance and non-covered custom-made devices fifty percent (50 %) of the balance is due at the casting appointment, with the balance due at the time of delivery; (4) Sunshine P+O will bill your insurance company as a courtesy to you; however, Sunshine P+O is not responsible for non-payment from the insurance company; (5) If, due to unforeseen circumstances, additional procedures and/or treatments are necessary beyond what has been previously approved, patients must make arrangements for payment; (6) Patients are expected to keep their accounts current while waiting for their insurance company to remit payment.

In consideration of Sunshine P+O efforts to supply patients with products and/or services to the patient, the patient or guarantor agree that each of them is responsible for payment. Payments may be made by check, money order, Visa or MasterCard. A \$40.00 fee will be assessed for any check returned for any reason.

NO REFUNDS will be given for the following items: CUSTOM MADE ITEMS, PROSTHETIC SUPPLIES (LINERS, SLEEVES, SOCKS), NON-STOCK, and SPECIAL ORDER ITEMS. All other items will be reviewed on a case by case basis.

Patient Complaint Process

We are committed to ensuring you are completely satisfied with the services and care you receive at Sunshine P+O. However, if for any reason you wish to file a complaint, any staff member can assist you in this confidential matter. You will be asked to complete a "Patient Complaint Form" to assist us in understanding your complaint or concern fully. Once the form is received, a company representative will investigate the complaint thoroughly and take the necessary actions to satisfy your complaint.

I have read and agree with the Payment and Policy agreement. I also certify the information provided by me is true, accurate and complete to the best of my knowledge.

Patient/ Parent/ Guarantor Signature

Date

Patient/ Parent/ Guarantor Printed Name

Relationship to Patient

If the patient is 18 or older the patient must sign



Sunshine Prosthetics + Orthotics Privacy Practices Acknowledgment, Consents, and Assignment of Benefits

Acknowledgment of Receipt of Notice of Privacy Practices and Company Policies

By signing below, I certify that Sunshine P+O has made available to me a Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of Sunshine P+O healthcare operations. The Notice of Privacy Practices also describes my rights and Sunshine P+O's duties with respect to my protected health information.

Sunshine P+O reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Consent for Contact

I, the undersigned, consent to be contacted by Sunshine P+O by phone call, e-mail, US Postal Service or other means to follow-up on my care.

Use of Images

By signing below, I understand that Sunshine P+O may use my likeness in a photograph or video as part of its marketing efforts including but not limited to publication in external communication and social media posts. I waive the right to inspect or approve the finished product wherein my likeness occurs. Additionally, I waive any right to royalties or other compensation related to the use of those images.

Consent to Provide Services and/or Products

I understand that by signing this agreement, I indicate my wish to purchase orthotic and/or prosthetic products or services, or both, from Sunshine P+O. I understand that I am under the supervision and care of my attending physician. I understand that my physician has prescribed the orthosis/prosthesis noted as part of my treatment. I also understand that due to the nature of the products supplied by Sunshine O+P that they cannot be returned.

Assignment of Benefits

I, the undersigned, hereby authorize Sunshine P+O to request on my/our behalf and to collect directly all public and private insurance benefits due for products and/or services supplied to me by Sunshine P+O. In the event payments for insurance benefits are made directly to any of the undersigned, the payee will endorse to Sunshine P+O all checks for such payments.

Consent to Coordinate Care and Release of Medical Records

By signing below, I authorize all medical personnel to provide information to Sunshine P+O concerning my medical history, as it may relate to my treatment. This includes collecting medical information from any physician, surgeon, medical facility and/or physical therapist seen by me. Sunshine P+O will comply with all HIPAA rules and regulations.

Insurance Coverage

By signing below, I agree to inform Sunshine P+O of any changes in my insurance coverage. If my insurance coverage changes or is terminated, I understand that I am responsible for all charges of services and devices delivered to me or in fabrication.

Patient Name Printed

Patient Date of Birth

Patient/Guardian Signature

Date

Guardian Printed Name

Relationship to Patient

Patient Name: _____

Today's Date: _____

MEDICAL HISTORY

Diagnosis: _____

Relevant Surgeries: _____

MEDICAL CONDITIONS (CHECK ALL THAT APPLY):

Height: _____

Weight: _____

☐ Heart Problems

☐ Hepatitis A, B or C

☐ Vision Problems

☐ Pacemaker/Defibrillator

☐ Hypertension

☐ Cerebral Palsy

☐ Parkinson Disease

☐ Seizure Disorder

☐ Vascular Disease

☐ HIV Positive

☐ Alzheimer Disease

☐ Scoliosis/ Kyphosis

☐ Stroke

☐ Rheumatoid Arthritis

☐ Spina Bifida

☐ Currently Pregnant

☐ Diabetes

☐ Obesity

☐ Clubfoot

☐ MRSA/ VRE

☐ Kidney Disease

☐ Osteoarthritis

☐ Muscular Dystrophy: _____

☐ Osteoporosis

☐ Pulmonary Disease (TB)

☐ Other: _____

Medications: _____

IDENTIFY ALL THAT IS TRUE TO HELP US IDENTIFY A PROPER TREATMENT PLAN:

STRENGTH/ MOBILITY:

Falls are never an issue

Near-falls are an issue for me

I currently use a prosthetic/ orthotic device

I have used a prosthetic/ orthotic device in the past

I currently use an assistive device (cane, Walker, crutches, etc.)

Other: _____

DIFFICULT WALKING CONDITIONS FOR ME INCLUDE:

Uneven terrain

Ascending/ descending Stairs

Ascending or descending hill/ ramp

Snow/ ice

Other: _____

WORK DETAILS:

I am currently not working

My job is _____

My job requires use of stairs

My job requires prolonged standing

My job requires walking long distance or duration

My job includes difficult walking conditions

MY DAILY ACTIVITIES INCLUDE:

Shopping

Preparing meals

Cleaning my home

Performing yardwork

Walking the dog

LIVING SITUATION:

I live alone

I live with _____

I care for children at home

I must use stairs at home

There are difficult walking conditions around my home

MY HOBBIES/OTHER ACTIVITIES INCLUDE:

Long walks

Hiking

Running

Gardening

Other: _____

OTHER PERTINENT INFORMATION: _____

Signature

Print Name

Relationship to Patient