PATIENT REGISTRATION FORM

Date:

TIDEWATER PROSTHETIC CENTER

REBUILDING LIVES. RESTORING HOPE.™

Patient Information

Name:	First Name MI Last Name		
DOB:		Social Security:	
Address:	Street City State Zip		
Gender:	☐ Male ☐ Female	Marital Status:	☐ Single ☐ Married ☐ Other
Home Phone:		Cell Phone:	Work Phone:
E-mail:			
Emergency Contact:		Phone:	
Referring Physician:			

Insurance Information

Primary:		Policy Number:	
Subscriber Name:		Subscriber Date of Birth:	
Secondary:		Policy Number:	
Subscriber Name:		Subscriber Date of Birth:	

Worker's Compensation

Case Manager:		Phone number:		Injury Date:	

Assignment of Benefits

*I authorize my insurance company to pay benefits directly to ***Tidewater Prosthetic Center***. I understand my insurance company may not pay for services that are not a covered benefit or are not considered medically necessary. I also understand that there may be benefit limitations with no-fault carriers as deductibles and benefit maximums may apply. I agree to be financially responsible for all services provided by ***Tidewater Prosthetic Center.***

HIPAA

***Notice of Privacy Practices**: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and healtcare operations, and the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you to read it carefully and completely before signing this consent.

Purpose of Consent**: By signing this form, you consent for ***Tidewater Prosthetic Center to use and disclose your protected health information to carry out treatment, payment activities, and healthcare operations.

Medicare Supplier Standards

*"The products and/or services provided to you by ***Tidewater Prosthetic Center*** are subject to the supplier standards contained in the Federal regulations shown at 42 Code of Federal Regulations Section 424.57©. These standards concern business professional and operational matters (e.g., honoring warranties and hours of operation). The full text of these standards can be obtained at http://ecfr.gpoaccess.gov. Upon request we will furnish you a written copy of the standards."

*** I have read, understood, and hereby agree to all of the terms stated above.**

Patient or Authorized Representative Signature Date