EASTERN SHORE ORTHOTICS & PROSTHETICS, INC.

Patient Information

Name ____

Address ______________________ City ______________ State ________ Zip ________

Home Phone ( ) ______________ Cell Phone ( ) ______________ Work Phone ( ) ______________

E-Mail Address ____

Social Security# ______________________ Driver's License # ______________________

Date of birth ______________ Age ______________ Female / Male ______________ Single / Married / Widow

Height ______________ Weight ______________ Date of injury/surgery/amputation ______________

Employer ____

Employer Address ____

Referring Physician ______________________ Diagnosis ______________________

Have you worn an orthotic or prosthetic device in the past 3 years? YES / NO
If yes, please explain type of brace and date worn

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If patient is under the age of 18, please answer the following

Person responsible for bill:

Name ______________________________________ Date of birth ______________

Address ______________________ City ______________ State ________ Zip ________

Home Phone ( ) ______________ Cell Phone ( ) ______________ Work Phone ( ) ______________

Social Security# ______________________ Driver's License # ______________________

Employer ____

Employer Address ____

Patient Name ______________________________ Account# ______________

EMERGENCY CONTACT INFORMATION

Name ______________________________ Relationship to patient ______________

Home Phone (   ) ______________ Cell Phone (   ) ______________ Work Phone (   ) ______________

INSURANCE INFORMATION

Primary Insurance ______________________________ Policy # ______________

Subscriber's Name ______________________________ Date of birth ______________

Secondary Insurance ______________________________ Policy # ______________

Subscriber's Name ______________________________ Date of birth ______________

WORKMAN'S COMPENSATION

Claims Adjustor ______________________________ Date of injury ______________

Phone Number (   ) ______________________________ Claim Number ______________

I authorize my insurance benefits to pay directly to Eastern Shore Orthotics & Prosthetics, Inc (ESOP). I also authorize ESOP, my insurance company, and my referring physician to release any information required to process my claims. I understand that I am financially responsible for any balance owed. I understand it is my responsibility to pay all co-pays and deductibles prior to delivery of any items. ESOP makes every effort possible to have your claim paid by your insurance company, in the event your claim is denied, I agree to pay my balance in full immediately.

I agree that if our balance becomes delinquent, defined as 90 days past due, and is referred to a collection agency, I shall be responsible for collection fees equal to 33 1/3% of the balance due in addition to the balance. I further understand and agree that if legal action is taken to collect the balance, I shall also be responsible for all court cost. I hereby waive my rights under the laws and constitution of Alabama to exempt my personal property from execution.

In the event my account becomes more than 60 days past due, I authorize ESOP, Inc and any of its officers, agents or employees, to request a credit report on me. I also understand any past due balances may be reported to one or all of the national credit bureaus. I also authorize ESOP and any of its officers, agents or employees to contact me by phone, cell phone, "text message," e-mail or any other universally used modes of communication as needed to confirm appointments, provide essential information or secure payment of outstanding past due balances.

I acknowledge that I have received the attached Notice of Privacy Practice and Medicare Supplier Standards, if applicable.

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Patient / Responsible Party Signature **Date**