Skyland Prosthetics & Orthotics, Inc.

Today's Date: _____ Gender: M / F How did you hear about us _____

Patient Name: _____ Date of Birth _____

**** Parent/Guardian** (if patient is minor) / **POA _____**

Social Security #_____ Email Address _____

Phone#_____ Work#_____ Cell# _____

Alternative Contact Name _____Relation _____Phone _____

Home Address

Street_____

City_____

State_____ Zip _____

Mailing Address

Street_____

City_____

State_____ Zip _____

***** Are you a Veteran? Yes No Which Branch Did You Serve _____**

***** Do you live in a skilled nursing facility? ____ If yes, which facility _____**

Referring Physician _____ Phone_____

Primary Care Physician _____ Phone_____

Diabetic Physician _____ Phone _____

Podiatrist _____ Phone _____

***** Are you Amputee? YES NO If yes, when was your amputation? _____**

***** Has Medicare provided you with a power wheel chair? YES NO**

PAST MEDICAL HISTORY

Do you now or have you ever had:

- ❑ Allergic to Latex
- ❑ Alzheimer's Disease
- ❑ Arthritis
- ❑ Asthma
- ❑ Atrial Fibrillation
- ❑ Blood Clots (Thrombosis)
- ❑ Cancer (type) _____
- ❑ COPD
- ❑ Congestive Heart Failure
- ❑ Diabetes
- ❑ Eczema / Psoriasis
- ❑ Emphysema
- ❑ Epilepsy (seizures)
- ❑ Heart Attack
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ HIV/AIDS
- ❑ MRSA
- ❑ Osteoarthritis
- ❑ Poor Circulation
- ❑ Rheumatoid Arthritis
- ❑ Stroke (CVA)
- ❑ Tuberculosis
- ❑ Other_____
  _____

Skyland Prosthetics & Orthotics, Inc.

3845 Hendersonville Road, Fletcher, North Carolina 28732
Telephone: (828) 684-1644 Facsimile: 828-684-0648

Authorization for Release of Medical Information

I authorize any holder of medical or other information about me to be released to ***Skyland Prosthetics & Orthotics, Inc.***, their assignees or successors, such communication being needed to determine benefits payable for related claims for supplies or services furnished by ***Skyland Prosthetics & Orthotics, Inc.*** I authorize ***Skyland Prosthetics & Orthotics, Inc.*** to file my insurance claims and to release any medical information needed to my insurance company in order to process any medical claims.

This authorization does not have an expiration date. However, I do realize it is my right to cancel this request at any, time in writing. I understand that the information obtained may be subject to re-disclosure to a third party by ***Skyland Prosthetics & Orthotics, Inc.***

Assignment of Benefits / Financial Responsibility

I authorize my insurance company to pay benefits directly to ***Skyland Prosthetics & Orthotics, Inc.*** I understand I am responsible for the cost of the yearly deductible, co-insurance, copayments and/or non-covered items. If the patient balance is not paid as agreed, the balance will be turned over to an outside collection agency. I understand there will be a $25 charge for any checks returned for insufficient funds.

Photographic Consent

I authorize any photography of me and/or my device by ***Skyland Prosthetics & Orthotics, Inc.***, in connection with my diagnosis, treatment, or for reimbursement purpose. Photographs will be incorporated within the patient's medical record for documentation of care.

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 healthcare operations, of 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 will consent for ***Skyland Prosthetics & Orthotics*** to use and disclose your protected health information to carry out treatment, payment activities, and healthcare operations.

Medicare Supplier's Standards

"The product and/or services provided to you by ***Skyland Prosthetics & Orthotics, Inc.*** 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."

Return Policy

No returns on custom-made braces, inserts, custom shoes, compression garments, walking boots, cam boots, night splints, surgical shoes or any off the shelf item showing wear and tear including foul odors.

Returns for shoes and mastectomy supplies with original boxes / tags will be ***considered*** within 15 days of delivery, due to manufacturers' return policies. All returns will be based on the decision and discretion of the owners. I am receiving a copy of this policy for my records.

I hereby certify that I have read and fully understand and consent to the above provisions.

_____ _____

Print: Patient Name **Date of Birth**

_____ _____

Signature: Patient *or Guardian* **Today's Date**

Skyland Prosthetics & Orthotics, Inc.

Pippa Dolen, President
Shaun Dolen, Vice-President

Mailing Address:
Post Office Box 428
Skyland, North Carolina 28776
Telephone: 828-684-1644

Shipping Address:
3845 Hendersonville Road
Fletcher, North Carolina 28732
Facsimile: 828-684-0648

RETURN POLICY

Once the product has been taken from this facility the following policy is in place:

Orthotics:

No returns on custom-made braces, inserts, or custom shoes.
No returns on merchandise showing wear and tear including pet hair and foul odors.
Returns for off-the-shelf devices will be ***considered*** for shoes within 15 days of delivery, due to manufacturers' return policies.

Mastectomy:

No returns on merchandise showing wear and tear including pet hair and foul odors.
Returns for product in the original boxes with tags are ***considered*** within 30 days of delivery, due to manufacturers' return policies.

No returns for the following items due to the manufacturers' return policies:

Compression Stockings / Sleeves
Walking Boots
Night Splints
Air Casts
Surgical Shoes / Boots (Darco**)**

****ALL OF THE ABOVE WILL BE BASED ON THE DECISION AND DISCRETION OF THE OWNERS.***