STROBEL & ASSOCIATES PROSTHETICS AND ORTHOTICS, INC

Reason for Visit: _____ **Left** ☐ **Right** ☐

Name: (Last) _____ **(First)** _____ **(M.I.)** _____

Home Address: _____ **Email:** _____

City/State: _____/_____ **Zip Code:** _____

Home Phone: (_____) _____-_____ **Cell Phone:** (_____) _____-_____

Date of Birth: _____/_____/_____ **Gender: Male** ☐ **Female** ☐ **SS#:** _____-_____-_____

Marital Status: Single ☐ **Married** ☐ **Divorced** ☐ **Widowed** ☐ **Minor** ☐

Employer: _____ **Employer Phone:** (_____) _____-_____

Employer Address: _____ **City/State:** _____/____ **Zip:** _____

Emergency Contact: _____ **Relationship:** _____ **Phone:** (____) ____-_____

Address: _____**City/State:** _____/____ **Zip:** _____

Nearest friend/relative not living with you: _____ **Phone:** (____)_____-_____

Referring Physician: _____ **Phone:** (____) _____-_____

Primary Care Physician: _____ **Phone:** (____) _____-_____

Diagnosis of Illness/Injury: _____ **Left Right Date of onset:** ___/_____/____

Height: _____ **Weight:** _____

Are you diabetic? Y N Diabetic Physician:_____ **Phone:** (____) _____-_____

Have you received a device or any other orthosis/prosthesis directly related to this condition in the past? Yes ☐ **No** ☐ **If yes, when:** ____/____/_____ **please explain what you have, and from whom It was provided:** _____

How did you hear about Strobel & Associates Prosthetics and Orthotics, Inc.? _____

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

I have read and understand the above: _____

I give Strobel & Associates P&O permission to contact me via phone, email, or US mail for the purpose of my future care, appointments and/or advancements in technology regarding this service.

_____ _____

Patient Signature (or Guardian) **Date**

STROBEL & ASSOCIATES PROSTHETICS AND ORTHOTICS, INC

NAME: _____

Is injury related to: WORK ☐ AUTO ACCIDENT ☐ NON-ACCIDENT ☐ OTHER: _____

If "WORK" complete the following: Date of Injury: ____/____/_____ Claim #: _____

Employer name at time of injury: _____ Phone: (____) _____-_____

Address: _____ City/State: _____/_____ Zip: _____

Work Comp Insurance Company: _____

Address: _____ City/State: _____/_____ Zip: _____

Adjustor's Name: _____ Phone: (_____) _____-_____

***WE FILE YOUR INSURANCE FOR YOUR CONVENIENCE. VERIFICATION OF BENEFITS OR PRE-CERTIFICATION DOES NOT GUARANTEE PAYMENT OF A CLAIM. WE ALLOW SIX WEEKS FOR YOUR INSURANCE TO PAY, THEN PAYMENT IN FULL IS YOUR RESPONSIBILITY. THANK YOU IN ADVANCE FOR YOUR COOPERATION. ***

INSURANCE INFORMATION:

How do you intend to pay your portion: Cash ☐ Check ☐ Credit Card ☐ (Type:_____)

Primary Insurance: _____ Phone #: (_____) _____-_____

Policy ID#: _____ Group #: _____

Address: _____ City/State: _____/____ Zip: _____

Name of Insured: _____ Date of Birth: _____/_____/_____

Relation: Self ☐ Spouse ☐ Child ☐ Insured SS#: _____-_____-_____

Insured's employer: _____

Secondary Insurance: _____ Phone #: (_____) _____-_____

Policy ID#: _____ Group #: _____

Address: _____ City/State: _____/_____ Zip: _____

Name of Insured: _____ Date of Birth: _____/_____/_____

Insured's SS#: _____-_____-_____

ASSIGNMENT OF BENEFITS

I request that payment of authorized Medicare, Medicaid, or private insurance benefits be made to Strobel & Associates Prosthetics and Orthotics, Inc. ("Strobel & Associates") for any services furnished to me by Strobel & Associates. I hereby authorize Strobel & Associates to release any medical, financial or other information needed, now and in the future, to process any claim for payment of services provided to me by Strobel & Associates. I further authorize Strobel & Associates to release any other specific medical information needed by any other healthcare provider treating me for the specific medical condition related to the services provided to me by Strobel & Associates. I agree to be responsible for payment of any amounts not covered by my insurance plan or any amounts remaining after my insurance plan has made payment, including all deductibles, co-payments and coinsurance.

_____ _____ _____/_____/_____

Patient's Name (Printed) Patient's Signature (or Guardian) Date

Strobel & Associates Prosthetics and Orthotics, Inc.

PATIENT NAME: _____ ACCT #: _____

PATIENT CONSENT TO OBTAIN CONFIDENTIAL PATIENT INFORMATION

I, the undersigned, authorize any facility, organization, individual to release all necessary medical records to STROBEL & ASSOCIATES PROSTHETICS and ORTHOTICS, INC. (Strobel & Associates), for the purpose of continued care by STROBEL & ASSOCIATES. I understand that I have the right to examine and copy the information disclosed, unless deemed that such disclosure is not in my best interest.

Any use of disclosure of my personal health information will follow the purposes noted in STROBEL & ASSOCIATES' Notice of Patient Information Practices. I understand that I retain the right to revoke this consent by notifying the practice *in writing* at any time.

PATIENT/GUARDIAN OR RESPONSIBLE PARTY: _____DATE: _____

WITNESS BY CLINICAL REPRESENTATIVE: _____DATE: _____

CANCELLATION POLICY

STROBEL & ASSOCIATES strives to provide each patient with the highest quality of care while attempting to accommodate your schedule. Therefore, we reserve time allotments for each patient. When you cancel and appointment, or do not keep an appointment, this limits our ability to meet the scheduling needs of our other patients.

We do not charge a fee for cancellations, however, STROBEL & ASSOCIATES requests that you contact the office 24 hours in advance if you see the need to cancel a scheduled appointment.

Strobel & Associates Prosthetics and Orthotics, Inc.

PATIENT NAME: _____ ACCT #: _____

PATIENT CONSENT TO TREAT

I, the undersigned, do voluntarily agree and give my consent to STROBEL & ASSOCIATES PROSTHETICS and ORTHOTICS, INC. (Strobel & Associates), to furnish medical care and treatment considered necessary and proper for the condition for which I have been referred. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of my treatment rendered.

STROBEL & ASSOCIATES is authorized to release all information necessary, including medical records, pertaining to this condition to any agency concerning with the payment of my charges in order to secure payment. A photocopy of this agreement is to be considered as valid as the original.

PATIENT/GUARDIAN OR RESPONSIBLE PARTY: _____DATE: _____

WITNESS BY CLINICAL REPRESENTATIVE: _____DATE: _____

PATIENT CONSENT TO USE HEALTH INFORMATION

I have read and fully understand STROBEL & ASSOCIATES' Notice of Information Practices. I understand that STROBEL & ASSOCIATES may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice *in writing.* I also understand that STROBEL & ASSOCIATES will consider requests for restriction on a case-by-case basis, but does not have to agree to any requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in STROBEL & ASSOCIATES' Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice *in writing* at any time.

PATIENT/GUARDIAN OR RESPONSIBLE PARTY: _____DATE: _____

WITNESS BY CLINIC REPRESENTATIVE: _____DATE: _____

221 WEST PARKER ROAD, SUITE 510, PLANO, TEXAS 75023 PHONE (972) 516-9538 FAX (972) 516-9548

Strobel & Associates Prosthetics and Orthotics, Inc.

PATIENT NAME: _____ DATE: _____

PRESCRIPTION:_____

CLINICIAN: _____

REQUIRED

You must provide goals in order to proceed with the services

Please list your goals:
Short Term Goals (function within home, walking, etc.)

1. _____

   _____

2. _____

   _____

3. _____

   _____

Long Term Goals: (community mobility, eliminate use of assistive device, return to work, etc.)

1. _____

   _____

2. _____

   _____

3. _____

   _____

The goals provided above have been discussed between myself and the clinician.

Signature: Date:

_____ _____

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