POSI
Prosthetic Orthotic Solutions International

Facility: _____

PATIENT INFORMATION

Mr. Mrs. Miss □ Male □ Female
Patient Name _____ Date of Birth: _____
Home Address _____
City _____ State _____ Zip Code _____
Home Phone #: _____ Email: _____
Cell Phone #: _____ Marital Status: o Married o Single o Divorced o Widowed o Minor
Employer _____ Employer Phone # _____
Employer Address _____
City _____ State _____ Zip Code _____
Spouse/Parent/Guardian (Circle One) _____
Spouse/Parent/Guardian Home Phone # _____ Work Phone # _____
Nearest Relative/Friend Not Living With You _____ Phone # _____
Emergency Contact _____
Home Address _____
City _____ State _____ Zip Code _____
Home Phone # _____ Work Phone # _____
How did you hear about us? _____

MEDICAL INFORMATION

Referring Physician _____ Primary Care Physician _____
Nature of Injury _____ Date of Injury_____
Injury Related To: o Birth o Auto Accident o Other Accident o Work -- If Work Related, Please Answer the Following:
Employer at Time of Injury _____ Phone # _____
Address _____
City _____ State _____ Zip Code _____
Workers Comp. Insurance Name _____
Address _____
City _____ State _____ Zip Code _____
Phone # _____ Claim # _____
Adjuster Name _____ Extension # _____

INSURANCE INFORMATION

How do you intend to pay for your portion? o Cash o Check
Primary Insurance _____ Address _____
City _____ State _____ Zip Code _____Phone # _____
Policy # _____Group Name/Number _____
Name of Insured _____ Date of Birth _____
Relation to Patient: o Self o Spouse o Parent o Other _____ Insured's Employer _____
Secondary Insurance _____ Address _____
City _____ State _____ Zip Code _____Phone # _____
Policy # _____Group Name/Number _____
Name of Insured _____ Date of Birth _____
Relation to Patient: o Self o Spouse o Parent o Other _____ Insured's Employer _____

Assignment of Benefits / Authority for Release of Information/HIPAA Acknowledgement:

I request that payment of authorized Medicare, Medicaid, or private insurance benefits be made to POSI/Freedom Management Services, for any covered services furnished to me by this facility. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents, Champus and its agents, or to any private insurance company any information needed to determine these benefits or the benefits payable for related services. If this is a private insurance claim, I further agree to be responsible for the full amount of the charges from the date of delivery if my private insurance company does not pay for the charges in a timely manner, or my physician, or I fail to provide within thirty (30) days the information necessary to submit the claim for payment. I also hereby acknowledge that I have received a copy of The Notice of Privacy Practices for Physiotherapy-BMI, Inc. and hereby consent to the use and disclosure of my personal health information for the purposes of treatments, payment, and health care operations. I agree that, in order for Physio O&P to service my account or to collect monies you may owe, Physio O&P and/or our agents may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. Physio O&P may also contact me by sending text messages or emails, using any email address I provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

x _____
Beneficiary / Parent / Guardian Date