Cranial Kids PATIENT INFORMATION

PATIENT INFORMATION

PATIENT NAME:_____ DOB:_____
ADDRESS:_____
HOME PHONE:_____ CELL PHONE:_____
WORK PHONE:_____ EMERGENCY CONTACT PHONE:_____

PRIMARY INSURANCE

PATIENT NAME:_____ DOB:_____
ADDRESS:_____
HOME PHONE:_____ CELL PHONE:_____
WORK PHONE:_____ EMERGENCY CONTACT PHONE:_____

SECONDARY INSURANCE

SECONDARY INSURANCE:_____ PHONE:_____
ADDRESS:_____
POLICY #:_____ PHONE:_____

PHYSICIAN INFORMATION

REFERRING PHYSICIAN:_____ PHONE:_____
PRIMARY CARE PHYSICIAN:_____ PHONE:_____

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, 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 Cranial Kids to use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations

COMMUNICATION AUTHORIZATION

I authorize Cranial Kids to leave messages on my home phone/cell phone or contact me by e-mail at _____.

MEDICARE SUPPLIER STANDARDS

"The products and/or services provided to you by Orthomerica products inc. 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 operation). The full text of these standards can be obtained athttp:// ecfr.gpoaccess.gov. Upon request we will furnish you a written copy of the standards."

ASSIGNMENT OF BENEFITS

I authorize my insurance company to pay benefits directly to Cranial Kids. 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 Cranial Kids.

SIGNATURE

I HAVE READ, UNDERSTOOD, AND HEREBY AGREE TO ALL OF THE TERMS STATED ABOVE.

_____ _____
PATIENT OR AUTHORIZED REPRESENTATIVE SIGNATURE: DATE: