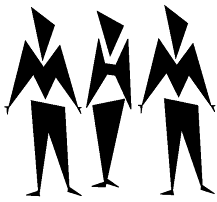

M. H. MANDELBAUM

ORTHOTIC & PROSTHETIC SERVICES, INC.

…a name people trust for personalized orthotic & prosthetic care

Patient Information

Patient Name			Home Phone ( )	
Home Address			Cell Phone ( )	
City		State	Zip	
Employer			Business Phone ( )	
Date of Birth	Age	Height	Weight	Sex (M / F)
Social Security No.	Place of Service			
Are you Diabetic? Yes / No	Diagnosis:			
List any pertinent medical history, allergies, etc.:				
Referred By		Primary Care Physician		
Nearest Relative		Relative Phone ( )		
Have you ever worn an orthotic/prosthetic device in the past? yes ___ no___ If yes, when?___________				

Primary Insurance Information

Insurance Company		Carrier Phone ( )
Address		City/State/Zip
Policy Holder	Relationship	Policy Holder Employer
Policy Holder SS#		Employer Address
Policy Holder Date Of Birth		Policy Holder ID #

Secondary Insurance Information

Carrier		Carrier Phone ( )
Address		City/State/Zip
Policy Holder	Relationship	Policy Holder Employer
Policy Holder SS#		Employer Address
Policy Holder Date Of Birth		Policy Holder ID #
Contact Name		Contact Phone ( )

I CERTIFY THAT THE INFORMATION I HAVE PROVIDED IS TRUE AND COMPLETE AND AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS THIS CLAIM TO ANY INSURANCE COMPANY, ADJUSTER, CASE MANAGER OR ATTORNEY INVOLVED IN THIS CLAIM.
I REQUEST PAYMENTS OF GOVERNMENT BENEFITS TO MYSELF OR TO **M. H. MANDELBAUM O&P SVCS., INC..** IF ASSIGNMENT IS ACCEPTED.
I AUTHORIZE PAYMENT OF MEDICAL BENEFITS DIRECTLY TO **M. H. MANDELBAUM O&P SVCS., INC..**
I AUTHORIZE THIS FACILITY TO INITIATE A COMPLAINT TO THE INSURANCE COMMISSIONER FOR ANY REASON ON MY BEHALF.
I PERMIT A PHOTOCOPY OF THIS ASSIGNMENT/AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.
I UNDERSTAND THAT I AM FULLY RESPONSIBLE TO M. H. MANDELBAUM O&P SVCS., INC. FOR ANY BALANCE NOT COVERED BY INSURANCE.
PAST DUE AMOUNTS (OVER THIRTY DAYS FROM DATE OF SERVICE) ARE SUBJECT TO 1.5% SERVICE CHARGE PER MONTH.
I SHALL BE PERSONALLY RESPONSIBLE FOR ANY UNPAID BALANCES WITHIN THIRTY DAYS OF DATE OF SERVICE INCLUDING SERVICE CHARGES, COLLECTION FEES AND ATTORNEY FEES INCURRED.

SIGNATURE ON FILE: I AUTHORIZE M. H. MANDELBAUM O&P SVCS., INC. TO USE THE PHRASE “SIGNATURE ON FILE “ ON ANY CLAIM FORMS OR CREDIT CARD SLIPS IN ORDER TO PROCESS AND OR PAY FOR SERVICES RENDERED. MY SIGNATURE ON FILE REMAINS EFFECTIVE UNTIL REVOKED BY ME IN WRITING, HOWEVER I UNDERSTAND I AM STILL RESPONSIBLE FOR ANY UNPAID BALANCES, INTEREST CHARGES AND COLLECTION FEES.
THIS ASSIGNMENT OF BENEFITS HAS BEEN EXPLAINED TO MY FULL SATISFACTION, AND I UNDERSTAND ITS NATURE AND EFFECT.

NO REFUNDS OR RETURNS ON CUSTOM MADE OR CUSTOM FIT DEVICES OR ANY DEVICE WORN OUT OF PLACE OF SERVICE (SEE WARRANTY AND SUPPLIER STANDARDS POLICY). THE COMPANY’S PRIVACY POLICY HAS BEEN MADE AVAILABLE TO ME.

____

(Signature of Policyholder or Authorized Person) (Date)

Patient Information Form 04/10/2009

116 Oakland Avenue, Port Jefferson, NY 11777 • 631-473-8668 / fax 631-473-8691