LEIMKUEHLER
ORTHOTIC-PROSTHETIC CENTER INC.
Specialists Since 1948

HIPAA Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive. By signing this form, I understand that:

Protected health information may be disclosed or used for treatment, payment, or healthcare operations.

-The practice reserves the right to change the privacy policy as allowed by law.

-The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.

-The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.

-The practice may condition receipt of treatment upon execution of this consent. **Initial _____**

I authorize any holder of medical or other information about me to release to the insurance payer, or any of its agents, any information needed to determine payment for these benefits or benefits for related services. 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 the payment including but not limited to all the deductibles, co-payments and co-insurances and any non-covered items.

ASSIGNMENT OF BENEFITS/PATIENT AUTHORIZATION TO RELEASE INFORMATION

I request that payment of authorized Medicare/insurance benefits be made on my behalf to Leimkuehler Orthotic-Prosthetics Center, Inc for any services furnished to me by Leimkuehler Orthotic-Prosthetics Center, Inc. I authorize any holder of medical information about me to release the health care financing administration and its agents and any information needed to determine these benefits.

I CERTIFY THAT THE INFORMATION PROVIDED BY ME IS ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

Initial: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OR PRIVATE PRACTICES

I certify that I have received a copy of Leimkuehler Orthotic-Prosthetics Center, Inc Notice of Privacy Practices. The notice of Privacy Practices describes the type of uses and disclosures of my protected health information that might occur in my treatment, payment of bills or in the performance of Leimkuehler Orthotic-Prosthetics Center, Inc health care operations. The Notice of Privacy Practices also describes my right and Leimkuehler Orthotic-Prosthetics Center, Inc, duties with respect to my protected health information. The Notice of Privacy Practices is posted at 205 N Leavitt Road, Amherst Ohio 44001. Leimkuehler Orthotic-Prosthetics Center, Inc

reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or by asking for one at the time of my next appointment.

Photo Release Form

I hereby authorize and give permission to Leimkuehler Orthotic-Prosthetics Center, Inc or its otherwise entitled branch offices, to interview, photograph, videotape and/or film and use such materials, including medical information relevant to my rehab program, in any matter which assists my treatment and/or evaluation process, or which helps to increase public awareness and knowledge regarding the fields of orthotics and prosthetics.

I grant permission to Leimkuehler Orthotic-Prosthetics Center, Inc and its affiliate offices, to use my name, personal and medical information, and photograph, video, film, and/or x-rays, in my patient chart, in the newsletter, and to release such materials to professional orthotics and prosthetics publications as well as the general print and electronic media to advance public knowledge and awareness of the field of orthotics and prosthetics. **Y_____ N_____**

May we phone, email, or send a text to you to confirm appointments? Y_____ N_____
I understand that email and text messages are not considered a completely secure form of communication and I am authorizing Leimkuehler Orthotic-Prosthetic Center, Inc to send emails and/or text messages which may contain my protected health information to the following cellular devices and/or email accounts. I understand that I may change or rescind this authorization at any time by contacting Leimkuehler Orthotic-Prosthetic Center, Inc
May we leave a message on your answering machine at home or on your cell phone? Y_____ N_____
May we discuss your medical condition with any member of your family? Y_____ N_____

Print Name: _____ Date: _____

Signature: _____

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Medical History Form

Have you experienced any of the following:

- ☐ Heart Problems
- ☐ Hypertension
- ☐ Vascular Disease
- ☐ Stroke
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Osteoporosis
- ☐ Hepatitis A or B
- ☐ Hepatitis C
- ☐ HIV Positive
- ☐ Rheumatoid Arthritis
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Pulmonary Disease
- ☐ Vision Problems
- ☐ Parkinson's Disease
- ☐ Alzheimer Disease
- ☐ Psychiatric Problems
- ☐ Alcoholism
- ☐ MRSA/STAPH Infection

List any other conditions that may affect your treatment:

_____

Medications you are currently taking that may affect your treatment:

_____

Current Height: _____ **Current Weight:** _____ **Shoe Size:** _____

Referring Physician: _____

Any amputations?

_____

Any traumas?

_____

Any recent falls?

_____

Therapy history:

_____

Have you ever received any orthotics/prosthetic items before? If so when?

_____

Additional information you would like us to know:

_____

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Patient Information Sheet

Date: _____

Patient's Name: _____ **Date of Birth**: _____

Parent/Guardian Name: _____

Are you currently residing in a nursing home: **Yes**_____ **No**_____ **Where**_____

Are you currently under hospice care: **Yes**_____ **No**_____ **Where**_____

Home Address: _____

City: _____ **State**: _____ **Zip**: _____

Email Address: _____

Cell: _____ **Home Phone**: _____

Social Security #: _____ **Gender**: _____ **Marital Status**: _____

Diagnosis: _____ **Date of injury or illness**: _____

Height: _____ **Weight**: _____ **Shoe Size**: _____

Infectious Diseases: _____

List of Medications: _____

List of Allergies: _____

Ever worn an O&P device before? _____ **If so, when?** _____

How did you hear about us? _____

Physician's Name: _____ **Phone #** _____

Surgeon's Name: _____ **Phone #** _____

Physical Therapist: _____ **Phone #** _____

Would you like to receive future mailings from us? Yes _____ **No** _____

How would you like us to verify your appointments? Via phone call _____ **or text** _____