



**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 orthotic or prosthetic 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 \_\_\_\_\_



**Medical History Form**

**Have you experienced any of the following:**

- |  |  |  |
|--|--|--|
| <input type="radio"/> Heart Problems   | <input type="radio"/> Hepatitis A or B     | <input type="radio"/> Vision Problems      |
| <input type="radio"/> Hypertension     | <input type="radio"/> Hepatitis C          | <input type="radio"/> Parkinson's Disease  |
| <input type="radio"/> Vascular Disease | <input type="radio"/> HIV Positive         | <input type="radio"/> Alzheimer Disease    |
| <input type="radio"/> Stroke           | <input type="radio"/> Rheumatoid Arthritis | <input type="radio"/> Psychiatric Problems |
| <input type="radio"/> Diabetes         | <input type="radio"/> Obesity              | <input type="radio"/> Alcoholism           |
| <input type="radio"/> Kidney Disease   | <input type="radio"/> Osteoarthritis       | <input type="radio"/> MRSA/STAPH           |
| <input type="radio"/> Osteoporosis     | <input type="radio"/> Pulmonary Disease    | <input type="radio"/> Infection            |

**List any other conditions that may affect your treatment:**

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**Medications you are currently taking that may affect your treatment:**

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**Current Height:** \_\_\_\_\_ **Current Weight:** \_\_\_\_\_ **Shoe Size:** \_\_\_\_\_

**Referring Physician:** \_\_\_\_\_

**Any amputations?**

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**Any traumas?**

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**Any recent falls?**

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**Therapy history:**

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**Have you ever received any orthotic or prosthetic items before? If so, when?**

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**Additional information you would like us to know:**

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### 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:** \_\_\_\_\_



**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**\_\_\_\_\_

Please list the names of anyone you give us permission to discuss your medical condition with:

\_\_\_\_\_

**Print Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature:** \_\_\_\_\_