Patient Registration

Georgia Carolina Orthotic Centers
2301 Wrightsboro Road
Augusta, Ga 30904
706.496.3911

Patient Name: _____ _____ _____ **Gender: (M / F)**
First M.I. Last

Date of Birth: _____ **Age:** _____ **Height:**_____ **Weight:**_____

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

Primary Phone #: _____**cell / home / work Alternate Phone #:** _____ **cell / home / work**

Email Address: _____

Preferred Method of Contact: Phone Text Email (circle one) May we leave a message? (Y or N)

Employer: _____ **Phone#:** _____

Referring Physician: _____ **Primary Care Physician:** _____
(Physician that is requesting the orthotic)

Have you received a similar service in the past 5 years? YES / NO (please circle)

Was your injury work related? YES / NO (please circle) If yes, Contact Person: _____

Date of occurrence: _____ **Claim Number if Applicable:** _____

Was Your Injury the result of an accident? YES / NO (please circle)

Please list nature of accident: (automobile, fall or other)_____ **Date of Occurrence:**_____

Person Financially Responsible/Guarantor: _____ **Relationship to Patient:** _____

Contact #: _____ **Email:** _____

☐ **(CHECK IF ADDRESS IS SAME AS ABOVE)**

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

Person to Notify in Case of Emergency: _____ **Phone #:** _____

INSURANCE INFORMATION (Policy Holder)

Primary Insurance Company: _____ **I D#:** _____**Group #/Name:** _____

Date of Birth: _____ **Social Security Number:** _____ **Contact Number:**_____
Policy Holder Policy Holder

Secondary Insurance Company: _____ **ID#:** _____ **Group #/Name:** _____

Relationship of Patient to the Policy Holder (circle one) SELF / HUSBAND / WIFE / CHILD / PARENT / OTHER:

******Please see reverse side for signature and Notice of Privacy Practices******

Patient consent & acknowledgement form

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I have been given a copy of **Georgia Carolina Orthotic Centers(GCOC)** Notice of Privacy Practices and understand these rights. I also understand that it is my responsibility to notify **GCOC** in writing of any restrictions to my patient file.

OFFICE PROCEDURES

I hereby give consent to **GCOC** to provide treatment and service the Provider may deem necessary.
I understand that I am responsible for payment of charges and that payment is due at the time of service, or I hereby assign insurance benefits to be paid directly to **GCOC** for professional fees.
I understand that I am responsible for charges not covered by my insurance policy.
I understand that any amounts which are 90 days past due could be eligible for potential collections and turned over to a Collection Agency unless prior arrangements have been made with **GCOC.** Collection Agency fees are recognized to be my/*responsible party(s)* responsibility.
I understand that I am responsible for a fee of $25.00 for any returned check
I understand that I may need to assist in obtaining my medical records and may be charged if **GCOC** is billed a fee for medical records.

RELEASE OF CONFIDENTIAL INFORMATION & AUTHORIZATION

I hereby permit a copy of this authorization to be used in place of any original signed document. I understand that this original will be placed in my patient file to be kept at the **GCOC** office.
I hereby consent and grant permission for Practitioners employed by **GCOC** to discuss my medical treatment for orthotics with my referring physician, primary care physician, physical therapist, occupational therapist, hospital and/or rehabilitation staff, relating to my care and treatment.
I hereby authorize any practitioner examining and/or treating me, to release to any third party (*such as an insurance company or governmental agency*) any medical information and records concerning the diagnosis and treatment when requested for use in determining payment of claims. I understand that this is a Lifetime Release of Information unless I have placed restrictions in my patient file and have completed the necessary forms.
In addition, I hereby consent for **GCOC** to discuss my medical treatment with the following:

Name	**Relationship**	**Name**	**Relationship**

I hereby consent and authorize **GCOC** to file medical claims for treatment, electronically or manually, to my insurance carrier(s) for services rendered to me.

I have read, understand, and agree to all the above.

Patient's Signature	Patient's Printed Name	Date Signed

Representative's Signature	Representative's Printed Name	Date Signed