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

Patient Registration

Patient Name: _____ _____ _____ **Gender:** _____
First M.I. Last

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

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

Primary Phone #: _____ **May we leave a message?** _____

Email Address: _____

Parent/Guardian Employer: _____ **Phone#:** _____

Please list parent(s)/guardian(s): (this will also serve as authorization for patient information disclosure)

Parent/Guardian: _____ **Contact #:** _____
Last First

Parent/Guardian: _____ **Contact #:** _____
Last First

Pediatrician: _____ **Referring Physician:** _____

Has Patient received a similar service in the past 5 years? YES / NO Date Received: _____

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 #:** _____
Policy Holder Policy Holder

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

Relationship of Policy Holder to thePatient (circle one) **PARENT / LEGAL GAURDIAN / 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 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 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, as the parent or legal representative of the minor child listed above, have read, understand, and agree to all the stated above.

Parent of Legal Representative's Signature	Representative's Printed Name	Date Signed