Atlantic
Prosthetic Services

PATIENT INFORMATION

Please complete all information in print. Have all insurance cards available for copies.

Last: _____ First: _____ MI: _____

DOB: _____/_____/_____ Age: _____ M / F SSN#: _____

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

Home #: (_____) _____ Work #: (_____) _____ Cell #: (_____) _____

Email: _____

Responsible Party: _____ Relationship: _____ SSN #: _____

Emergency Contact: _____ Relationship: _____ Ph #: (_____) _____

Who referred you to our office? _____

Primary Physician: _____ Ph #: (_____) _____

Referring Physician: _____ Ph #: (_____) _____

Primary Insurance: _____ ID#: _____

Secondary Insurance: _____ ID#: _____

Location? ☐Wilmington ☐ Whiteville ☐ Supply ☐ Home ☐ School/Daycare ☐ Facility

School/ Facility: _____ Ph # :(_____) _____

Contact: _____ Title: _____ Ph # :(_____) _____

Authorization of Payment

I request payment of authorized benefits of Medicare/ Medicaid or Private Insurance to be made to Atlantic Prosthetic Services, 1142 Shipyard Blvd. Wilmington, NC 28412 for any services rendered on my behalf. I authorize any holder of medical information about me, to release all information required for billing purposes. This authorization is valid for one year from signature date. I understand I will be responsible for any unpaid balance for services provided. I agree that I will be fully liable for all charges incurred by myself that my insurance company will not pay due to non-covered charges, deductibles, co-pays, non-allowed or any other reason. If I have any questions regarding this, I will speak with someone in the billing office.

Please check box and sign for information provided:

☐ **Patient Bill of Rights** ☐ **Info. Release Authorization** ☐ **CMS Supplier Standards** ☐ **HIPAA/Privacy Practices**

Patient/ Responsible Party Signature _____ ***Date*** _____

Chart # _____ Specialist: Jeff / Bob / Aaron / Lindsey