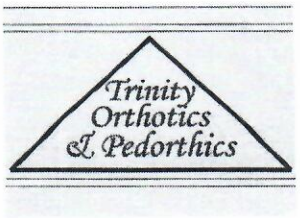


Trinity Orthotics and Pedorthics

Patient Information

Please read carefully and complete in full. Thank you!

Patient Name: _____

Mailing Address: _____

City_____ **State** _____ **Zip Code**_____

Home Phone_____ **Cell Phone** _____

Email Address _____

Single **Married** **Divorced** **Separated** **Widow**

SSN _____ **Age**_____ **Date of Birth**_____

Patient's Employer _____ **Work Telephone**_____

Employer's Address_____

City _____ **State** _____ **Zip Code**_____

Occupation _____ **Name of Supervisor** _____

Emergency Contact_____

Emergency Number_____

Insurance Provider(s) _____

Subscriber Name_____ **Subscriber DOB**_____

Subscriber SSN_____

I hereby grant consent of Trinity Orthotics & Pedorthics to use & disclose all information regarding my medical history in accordance with the HIPPAA guidelines. **A copy of the HIPAA guidelines is available in our lobby. If you would like a copy to take home, please ask at the front desk. By signing I Acknowledge that I have been provided a copy of the HIPPAA guidelines to read.**

I have read the information on this sheet. I certify that this information is correct to the best of my knowledge. I understand payment is due at time of service. I understand and agree that I am financially responsible for all charges not covered by my insurance company whether it is for non-covered services, non-met deductibles, or pre-existing conditions.

✓ Signature_____ Date_____

Is patient under Home Health Care/Skilled Nursing? _____

Patient Information- PLEASE READ CAREFULLY AND COMPLETE IN FULL

Name of Referring Dr._____ Phone Number_____

Diagnosis_____

Primary Care Dr._____ Phone Number_____

Was patient involved in an accident? Yes___ No___

Is this a Worker's Comp Claim?

Yes___ NO___ Date of Injury_____

Type of Accident: Work__ Auto__ Home__ Other__

Have you received this same type of product within the last five (5) years from any other provider? Yes__ No__

Height_____ Weight_____

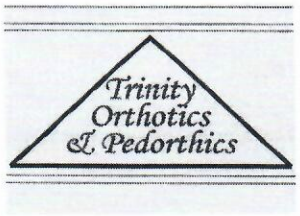
Please explain your diagnosis and the reason for your visit: _____

_____

_____

THE ABOVE INFORMATION IS COFIDENTIAL AND USED ONLY FOR FILING INSURANCE CLAIMS ON YOUR BEHALF

TRINITY ORTHOTICS & PEDORTHICS
2905 BOB WALLACE AVENUE
SUITE B
HUNTSVILLE, AL 35805
P: (256) 203-2647 f: (256) 964-8134



Equipment Warranty

I understand that the components of my device(s) are fully guaranteed under normal use for 90 days and that Trinity Orthotics & Pedorthics will make repairs to my device(s) as necessary and free of charge, during the warranty period. I understand that this guarantee does not apply to changes in my physical weight, condition, nor any other physiological changes that may occur, or to any alterations made by anyone other than Trinity Orthotics & Pedorthics. I have been instructed that under Public Health Law Title 22/Section 10.1 PROHIBITS THE RETURN OR EXCHANGE OF ANY TYPE OF BRACE, PROSTHESTIC DEVICE(S), SUPPORTS, SOCKS, COMPRESSION HOSE, ETC.

Additional Comments:

_____

_____

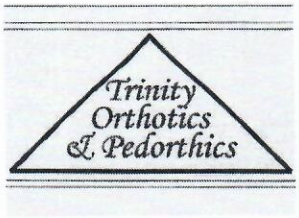
_____

_____ _____

Patient's Signature Date

_____ _____

Company Representative Date



HIPAA Compliance Patient Consent 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 the 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.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____