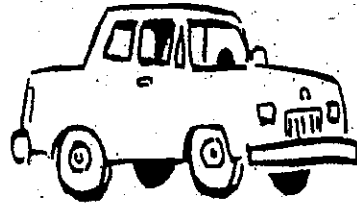


WORKMANS COMP/AUTO INFORMATION



SOCIAL SECURITY # _____ CLAIM# _____

PRESCRIPTION READS _____

DR.'S NAME _____

DATE OF INJURY _____ TYPE OF INJURY _____

ADJUSTER'S NAME _____ PHONE# _____

INSURANCE NAME _____

APPROVED / DISAPPROVED BY: _____

CONTACT PERSON: _____

ADDRESS TO SEND CLAIM _____

ATTENTION TO: _____

COMMENTS

RECORDS RELEASE AUTHORIZATION

I HEREBY AUTHORIZE YOU TO RELEASE TO :

Abilities Unlimited, Inc.

245 Parkside Drive

Colorado Springs, CO 80910

THE MEDICAL RECORD IN YOUR POSSESSION, CONCERNING MY
TREATMENT WHILE UNDER YOUR CARE

PATIENTS NAME: _____

ADDRESS: _____

DATE OF BIRTH: ____ / ____ / ____ S.S.N.: _____

SIGNATURE: _____ DATE: ____ / ____ / ____

Acknowledgement of Receipt of Notice of Privacy Practices

I certify that I have been offered a copy of **ABILITIES UNLIMITED'S** Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills, or in the performance of **ABILITIES UNLIMITED'S** healthcare operations. The Notice of Privacy Practices also describes my rights and **ABILITIES UNLIMITED'S** duties with the **LOBBY BULLETIN BOARD** and on **ABILITIES UNLIMITED'S** website at WWW.OANDP.COM/ABILITES.

ABILITIES UNLIMITED 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, asking for one at the time of my next appointment, or accessing **ABILITIES UNLIMITED'S** website.

Signature of Patient or Personal Representative

Name of Patient or Personal Representative

Date

Description of Personal Representative's Authority

Abilities Unlimited, INC
Policies and Procedures Awareness Sheet

- All patient information must be updated on a yearly basis, please be prepared to update your information at this time. Also, if you have an insurance change or change of address, please inform the front desk immediately.
- In order to provide services, we *must* have a prescription from your doctor before the time of service. The necessary documentation, such as Certificates of Medical Necessity and Therapeutic Shoe forms, must be obtained before we can dispense any devices.
- A copy of your current insurance card *must* be present at each office visit in order for us to file a claim with your insurance company. Failure to do so may result in either being asked to reschedule the appointment, or to pay for your visit in full today. This is not meant to be an inconvenience for you, but rather a way of ensuring proper billing of your claims.
- Financial Policy: to the extent that your health and accident insurance coverage pays for orthotic/prosthetic services, we are happy to assist you in collecting your benefits; however, this *does not* relieve you from financial responsibility of paying the cost of medical care. We will bill your insurance as a courtesy at no charge; however, if your insurance does not pay within 60 days, you will be responsible for the balance due. After this time, you will be responsible for contacting your insurance for payment.
- If you are more than 20 minutes late for a scheduled appointment, we will have to reschedule your appointment for a later date.
- If you are allergic to latex rubber, please inform your practitioner. Please dispose of needles in the appropriate containers. Diapers cannot be disposed of in this facility.
- If you are waiting more than 10 minutes in an exam room, please inform the front desk immediately.
- Please check with the front desk to complete any necessary documents before leaving from your appointment.

I have read and understood the information provided above by Abilities Unlimited, Inc and I will, to the best of my abilities, comply with these policies.

Patient or Guardian Signature

Date