Bay Orthopedic and Rehabilitation Supply Company Inc.

Visit www.bayorthopedic.com

Corporate Headquarters – 616 East Jericho Tpke. Huntington Station, N.Y. 11746

Regional Offices – Suffolk County, Nassau County, Queens County (NYC)

PATIENT INFORMATION

Patient Name _____ **Today's Date**___/___/_____

Patient Home Address _____

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

Date of Birth ___/___/_____ **Age** _____ **Height** ___**Ft.**___**In.** **Weight** _____**Lbs.**

Last 4 digits of SS # _____ **Sex M/F** _____ **Marital Status: S M other**____

Home Phone (**)** _____ - _____ **Cell Phone (** **)**_____-_____

E-Mail _____ **Work Phone (** **)**_____- _____

Please check best telephone to contact you Home ___ **Cell** ____ **Work** ____

Occupation_____ **Employer Name /School**_____

Name of Person Insured _____**Date of Birth of Insured** ___/___/___

Name of Insurance Co._____ **ID#**_____**Phone (**___**)**___-_____

Name of person with you during fitting _____ **Relationship** _____

Name of closest relative in Case of Emergency _____**Phone (** **)**____-_____

What is the condition or illness that caused you to seek medical attention? _____

_____

What is the name of your referring doctor? _____**Phone (** **)**____-_____

When is your next follow up visit with your referring doctor? _____

What is the name of your Primary Care Doctor? _____

Have you been to Bay Orthopedic before? Yes/No____ **if yes how long ago?**_____

Are you Diabetic? Yes/No_____ **Have you smoked in last 3 months? Yes/No**_____

Are you allergic to any materials like latex, neoprene etc? Yes/No. If so what?_____

Do you have any circulation impairment? Yes/No _____ **Do you experience edema or swelling in any body parts? Yes/No** _____ **Where?**_____

Do you have any previous knowledge of what was prescribed for you? Yes/No____

Have you worn a device for this condition within the last 5 years? Yes/No_____

Do you have any medical condition or physical limitation that you think would interfere with the device your doctor has prescribed for you? Yes/No____ **If the answer is yes please describe that condition**_____

* I CERTIFY THAT THE INFORMATION I PROVIDED IS TRUE & COMPLETE & AUTHORIZE THE RELEASE OF MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS THIS CLAIM TO ANY INSURANCE COMPANY/ATTORNEY INVOLVED.
* I AUTHORIZE PAYMENTS DIRECTLY TO Bay Orthopedic & Rehab. Supply Co. Inc. IF ASSIGNMENT HAS BEEN ACCEPTED.
* I PERMIT A PHOTOCOPY OF THIS ASSIGNMENT/AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.
* I AM AWARE THAT COPIES OF THIS FORM AS WELL AS HIPAA PRIVACY PRACTICES AND MEDICARE SUPPLIER STANDARDS ARE POSTED IN THIS OFFICE & THAT IF I WANT A COPY THEY ARE AVAILABLE HERE OR ON BAY WEBSITE
* I UNDERSTAND THAT I AM FULLY RESPONSIBLE TO Bay Orthopedic & Rehab. Supply Co. Inc FOR ANY BALANCE NOT COVERED BY MY INSURANCE COMPANY AND THAT I AM RESPONSIBLE TO PAY THESE BALANCES WITHIN 30 DAYS OR I WILL INCUR A SERVICE CHARGE OF 1 ½% PER MONTH AND COLLECTION AND ATTORNEY FEES INCURRED.
* SIGNATURE ON FILE: I AUTHORIZE Bay Orthopedic & Rehab. Supply Co. Inc. TO USE THE PHRASE SIGNATURE ON FILE ON ANY CLAIMS OR CREDIT CARD SLIPS IN ORDER TO PROCESS OR PAY FOR SERVICES RENDERED. MY SIGNATURE REMAINS EFFECTIVE UNTIL IT HAS BEEN REMOVED BY ME IN WRITING.
* THIS ASSIGNMENT OF BENEFITS AND THESE PAYMENT RULES HAS BEEN EXPLAINED TO MY FULL SATISFACTION.

Signed by _____ **Print Name** _____**Date**_____

Policyholder/Authorized Person