PLEASE FILL OUT
ALL THREE PAGES

O & P In Motion, Inc.

Pediatric and Adult
Orthotics & Prosthetics

(PLEASE PRINT) **Date:** _____

Patient: _____ **Birthday**: _____ **Sex:** _____ **Age:** _____
Last Name **First Name** **M.I.**

Address: _____
Apt. # **City** **State** **Zip Code**

Home Phone: _____ **Cell Phone:** _____ **Email:** _____

Patient: Single ___ **Married** ____ **Widowed** ____ **Separated** _____ **Divorced** ____ **SSN #:** _____

Patient Employer: _____ **Occupation:** _____

Business Address: _____ **Business Phone**: _____

In case of emergency contact: _____ **Phone#:** _____
Relation to Patient

Whom may we thank for referring you?: _____

If patient is a minor please complete below:

Father's Name: _____ **Driver's License:** _____ **SS #**: _____

Address: _____

Home Phone: _____ **Cell Phone:** _____ **Email:** _____

Father's Employer: _____ **Occupation:** _____ **Phone:** _____

Address: _____

If patient is a minor please complete below:

Mother's Name: _____ **Driver's License;** _____ **SSN #:** _____

Address: _____

Home Phone: _____ **Cell Phone:** _____ **Email:** _____

Mother's Employer: _____ **Occupation:** _____

Address: _____ **Business Phone #**: _____

Please kindly fill out All Insurance Information on Page 2 & 3 due to required by Insurance Companies
☺ THANK YOU ☺

PRIMARY INSURANCE

Medicare: _____ Medi-Cal: _____ CCS: _____ Private: _____ HMO: _____ No Insurance: _____

Policy holders name: _____ SS #: _____
(FOR BILLING PURPOSES)

Relationship to Patient: _____ Birthday: _____ Phone: _____

Name of Insurance: _____Group #: _____ Subscriber #: _____

Ins. Address: _____ Phone: _____

ADDITIONAL INSURANCE

Is patient covered by additional Insurance: Yes _____ No _____

Medicare: _____ Medi-Cal: _____ CCS: _____ Private: _____ HMO: _____ No Insurance: _____

Policy holders name: _____ SS #: _____
(FOR BILLING PURPOSES)

Relationship to Patient: _____ Birthday: _____ Phone: _____

Name of Insurance: _____Group #: _____ Subscriber #: _____

Ins. Address: _____ Phone: _____

ASSIGNMENT OF BENEFITS

I understand and agree that I am totally responsible and liable for payment of all charges assessed for professional services rendered and will pay that sum due upon demand. I understand that insurance claim forms will be submitted to my insurance company ***as a courtesy only*** and that I am primarily responsible for all charges regardless of any existing medical coverage. I understand that verification and authorization of insurance benefits are not a guarantee for payment by my insurance company. It is my responsibility to thoroughly understand my health insurance coverage, it's policy limitations, exclusions and changes. I further understand that O & P In Motion, Inc. cannot accept the final responsibility for collection on insurance or negotiation of settlement on a legal case.

In the event my insurance company forwards payment directly to me, instead of to O & P In Motion, Inc., I will immediately deliver such payment to O & P In Motion, Inc. I understand and agree that if it becomes necessary to commence legal action for the collection of any outstanding charges on my account, I will be responsible for any costs and court costs, in addition to the outstanding balance.

Patient Name: _____ Date: _____

Signature: _____
Patient or Legal Guardian

Please kindly fill out All Insurance Information on Page 2 & 3 due to required by Insurance Companies
☺ THANK YOU ☺

FINANCIAL POLICY

We have found that communication with our patients regarding our financial policy assists us in providing the best service to you. If you have any questions, please do not hesitate to discuss them with us.

Insurance Verification:

As a courtesy to you the insured, O & P In Motion, Inc. verifies insurance benefits and coverage at the time you begin our professional services. This verification is only an estimation of insurance benefits at the time of verification and in no way a promise on behalf of the insurance company to pay for any services rendered. The patient, or legal guardian, is liable for all charges not covered by insurance, whether or not such coverage agrees with the estimated amount. The patient, or legal guardian, is also responsible for charges if the insurance carrier denies the claim or deems that the treatment provided is not medically necessary. It is advisable for the patient to confirm that your policy will cover services rendered and to know if limitations apply. At each visit, you will be asked to pay your estimated portion (co-payment and/or deductible) for the treatment. For your convenience we accept CASH, CHECK, VISA, MASTERCARD OR DISCOVER.

Cancellation Policy:

We would greatly appreciate 24-hours notice if you are unable to keep your scheduled appointment. Appointment cancelled for non-emergency reasons with less than 24-hours notice may be subject to a **$30.00 cancellation fee**. ***Arrival more than 20 minutes after the time of your scheduled appointment may be considered a failed appointment and will be re-scheduled.***

Authorization:

I hereby authorize O & P In Motion, Inc. to provide professional services to me/my child/my legal ward. I understand that I am financially responsible for all fees incurred for me/my child/my legal ward's treatment, even if I have insurance which covers all or part of the cost of the treatment.

I hereby authorize release of medical information necessary to file a claim with my insurance carrier and assign benefits otherwise payable to me to: **O & P In Motion, Inc**. I also authorize my insurance carrier(s) to pay O & P In Motion, Inc. for any services rendered.

Patient's Name: _____ Date: _____

Signature: _____
Patient or Legal Guardian

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If you would like us to, we can automatically apply your portion of the bill to your Visa, MasterCard or Discover

I hereby authorize: O & P In Motion, Inc.
18913 Sherman Way
Reseda, CA 91335

To apply my balance to my charge card account. (Please Check one)

□ Visa □ MasterCard □ Discover

Account Number: _____ **Expiration Date**: _____
(must be 16 digits)

_____ **Date:** _____
Cardholder's Name (please print) **Cardholder's Signature**

Please kindly fill out All Insurance Information on Page 2 & 3 due to required by Insurance Companies
☺ THANK YOU ☺