



NEW PATIENT INFORMATION

This Section is for Office Use Only

Date: _____

Patient #: _____

PATIENT INFORMATION

Patient's First Name		M.I.	Last Name		Date of Birth	Social Security	
Street Address			City		State	Zip Code	Gender <input type="checkbox"/> M <input type="checkbox"/> F
Phone 1	Phone 2		Email			Marital Status <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D	

EMERGENCY/GUARDIAN CONTACT INFORMATION

Contact 1 First Name		M.I.	Last Name		Relationship to Patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Guardian		
Phone			Email				
Contact 2 First Name		M.I.	Last Name		Relationship to Patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Guardian		
Phone			Email				

PRIMARY INSURANCE INFORMATION *(required)*

Name of Insurance Company				Insurance Phone			
Member ID #		Group #			Plan #		
Insured's Name <i>(if not the patient)</i>		Insured's Date of Birth	Insured's Social Security		Relationship to Patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Guardian		
Adjuster's Name		Phone	Email		Fax		
Nurse/Case Manager's Name		Phone	Email		Fax		

SECONDARY INSURANCE INFORMATION *(complete this section if you have additional insurance coverage)*

Name of Insurance Company				Insurance Phone			
Member ID #		Group #			Plan #		
Insured's Name <i>(if not the patient)</i>		Insured's Date of Birth	Insured's Social Security		Relationship to Patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Guardian		
Adjuster's Name		Phone	Email		Fax		
Nurse/Case Manager's Name		Phone	Email		Fax		

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OTHER INSURANCE INFORMATION *(complete this section if you have additional insurance coverage)*

Name of Insurance Company			Insurance Phone
Member ID #	Group #	Plan #	
Insured's Name <i>(if not the patient)</i>	Insured's Date of Birth	Insured's Social Security	Relationship to Patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Guardian
Adjuster's Name	Phone	Email	Fax
Nurse/Case Manager's Name	Phone	Email	Fax

IF NOT INSURED

Self Pay: <input type="checkbox"/> Credit Card <input type="checkbox"/> Payment Plan <input type="checkbox"/> Check	Other: _____
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HEALTH CARE PROVIDERS

List all health care providers including physicians, specialists, clinicians, physical and occupational therapists, prosthetists and othotists so we may contact them to obtain patient's medical background/history and any other information that will help us process your claim.

Name 1	Specialty	Clinic
Address	Phone	Fax
Name 2	Specialty	Clinic
Address	Phone	Fax
Name 3	Specialty	Clinic
Address	Phone	Fax
Name 4	Specialty	Clinic
Address	Phone	Fax
Name 5	Specialty	Clinic
Address	Phone	Fax
Name 6	Specialty	Clinic
Address	Phone	Fax

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INJURY ILLNESS INFORMATION

Type of Illness/Injury		
<input type="checkbox"/> Chronic Pain	<input type="checkbox"/> Stroke	<input type="checkbox"/> Muscular Dystrophy
<input type="checkbox"/> Spinal Cord Injury	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> ALS
<input type="checkbox"/> Traumatic Brain Injury	<input type="checkbox"/> Brachial Plexus Injury	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Hemispherectomy	
Date of Injury or Onset of Illness/Symptoms	Is Injury/Illness the Result of an Accident? <i>(select all that apply)</i>	State Where Accident Occurred
	<input type="checkbox"/> Work-related <input type="checkbox"/> Auto <input type="checkbox"/> Other:	

EMPLOYMENT INFORMATION *(fill out only if injury/illness was work-related)*

Name of Employer	Employment Status
	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> Student <input type="checkbox"/> Other

DEVICE INFORMATION

What type of AxioBionics Device are you interested in?	
<input type="checkbox"/> Wearable Therapy®	<input type="checkbox"/> WalkAide®/Pace FES
<input type="checkbox"/> TripleFlex™	<input type="checkbox"/> Orthotics

EXISTING MEDICAL CONDITIONS

Cancer	<input type="checkbox"/> YES <input type="checkbox"/> NO	Heart Condition	<input type="checkbox"/> YES <input type="checkbox"/> NO
In remission?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Cardiac Demand Pacemaker	<input type="checkbox"/> YES <input type="checkbox"/> NO
Seizure Disorder	<input type="checkbox"/> YES <input type="checkbox"/> NO	Manufacturer:	Model:
On Anti-seizure Medications?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Phone:	
Seizures under control?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Cardiac Defibrillator	<input type="checkbox"/> YES <input type="checkbox"/> NO
Brain Impairments	<input type="checkbox"/> YES <input type="checkbox"/> NO	Manufacturer:	Model:
Varicose Veins	<input type="checkbox"/> YES <input type="checkbox"/> NO	Phone:	
Allergies to Adhesives	<input type="checkbox"/> YES <input type="checkbox"/> NO	Metal Implants in the body	<input type="checkbox"/> YES <input type="checkbox"/> NO
Blood Clots	<input type="checkbox"/> YES <input type="checkbox"/> NO	Location:	
Diabetes	<input type="checkbox"/> YES <input type="checkbox"/> NO	Other Medical Conditions	<input type="checkbox"/> YES <input type="checkbox"/> NO

Describe all conditions for which you checked YES, and any others not listed:

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PRIMARY INSURANCE INFORMATION

I authorize AxioBionics to release any medical or other information about me to my other healthcare providers or any other party for the purposes of treatment, payment, or healthcare operations; to my insurance company, health benefit plan, federal health benefits program, third-party payer, third-party administrator, or any other party, including any billing and/or collection service utilized by AxioBionics, necessary to process an insurance claim and/or to invoice and collect payment for items/services provided by AxioBionics and to release any medical or other information about me to auditors authorized by AxioBionics for the purpose of certification, licensure and accreditation, audit and/or review. I permit a copy of this authorization to be used in place of the original. I further authorize AxioBionics to contact me via telephone regarding services to be provided to me.

ASSIGNMENT OF INSURANCE BENEFITS

I certify that the information given by me is correct. I request that payment for authorized benefits are made on my behalf, I assign the benefits payable for covered services rendered by AxioBionics and authorize AxioBionics to submit claims to Medicare, Medicaid and/or commercial insurance carriers, other third-party payers, and administrators for payment. I authorize payment of my benefits directly to AxioBionics.

PAYMENT POLICY AND RESPONSIBILITY FOR PAYMENT

I understand that it is my responsibility to know my insurance benefits and coverage for all durable medical equipment, supplies and services provided to me by AxioBionics. I understand that AxioBionics, as a courtesy to me, will make every reasonable effort to bill all of my insurance companies for payment of my account. I understand that my insurance does not pay for everything and may not pay for the services or products (including durable medical equipment supplies) provided by AxioBionics. I understand that any remaining balance is my responsibility. I further agree to be personally and fully responsible for all items and services provided by AxioBionics that my insurance will not pay for and any deductibles and/or co-payments to the fullest extent allowed by law and my health benefits plan.

In the event that I fail to make a payment for which I am personally liable within thirty (30) days after invoice from AxioBionics, I understand that AxioBionics will charge interest on the outstanding balance at the rate of 1.5% per month until the outstanding balance is paid in full. I understand that payment may be made by cash, check, Visa, MasterCard, or American Express and I am responsible for making payment arrangements with AxioBionics if payment cannot be made in full upon receipt of the invoice. I further agree that in the event that any account is placed with an outside collection agency due to nonpayment, I will be responsible for any collection fees that may be added to my outstanding balance. I also understand that a \$35.00 office visit charge will be added to my account should I decide to cancel a service/device after casts, molds, or measurements have been made. I agree to pay this charge in the event it is incurred.

PATIENT ACKNOWLEDGEMENTS

1. I certify that I have received a copy of the AxioBionics Privacy Practices.
2. I am aware that I have a condition which requires orthotic and/or prosthetic treatment by AxioBionics. I understand that my physician has ordered this item/service as part of my treatment and that I am under his/her supervision.
3. I am also aware and acknowledge that representatives of AxioBionics have made no guarantees to me regarding the results of any examination or treatment.
4. I have read this authorization form or this authorization form has been read to me, and I understand its contents and agree to its terms.
5. I have completed this form fully and accurately, and have been given the opportunity to ask questions about this form and the services and products that may be provided.
6. I am competent and able to make decisions concerning the services and products that may be provided.

Patient's Signature	Print Name	Date
Authorized Representative's Signature	Print Name	Date
Relationship to Patient:		