Children's Orthotics and Prosthetics

810 S. Durango Dr., Ste 100, Las Vegas, NV 89145 • Phone 702.932.1300 • Fax 702.848.4990 • childrensop.com

General Information

Patient/Child's Name: *First* _____ *Middle* _____ *Last* _____

Preferred Name: _____

Gender: *Female* ◯ *Male* ◯ *Other* ◯ Date of Birth: _____ Age: _____

Preferred Language: ◯ *English* ◯ *Spanish* ◯ *ASL* ◯ *Other*: _____

Parent A Name: _____ Occupation: _____

Relationship to Patient: _____ Email: _____

Primary Address:

Street: _____ Apt. No: _____

City: _____ State: _____ Zip: _____

Parent's Work Phone: _____ Cell: _____

Parent B Name: _____ Occupation: _____

Relationship to Patient: _____ Email: _____

Primary Address:

Street: _____ Apt. No: _____

City: _____ State: _____ Zip: _____

Parent's Work Phone: _____ Cell: _____

Emergency Contact (other than child's parents):

Name: _____ Phone: _____

Street: _____ Apt. No: _____

City: _____ State: _____ Zip: _____

Physician Name: _____ Phone: _____

Therapist Name: _____ Phone: _____

Divorced or Separated Parents - please fill out this section

Who has custody? _____

Are there any legal restrictions that restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? *Yes* ◯ *No* ◯

If yes, you must provide a copy of any legal paperwork that supports this restriction.

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Insurance Information

Primary Insurance Name: _____

Primary Insurance Co. Address: _____

City, State, Zip: _____

Primary Insurance Co. Phone Number: _____

Policy Number: _____

Group Number: _____

Policy Holder Date of Birth: _____ Policy Holder SSN#: _____

Policy Holder relationship to patient: _____

Secondary Insurance Name: _____

Secondary Insurance Co. Address: _____

City, State, Zip: _____

Secondary Insurance Co. Phone Number: _____

Policy Number: _____

Group Number: _____

Policy Holder Date of Birth: _____ Policy Holder SSN#: _____

Policy Holder relationship to patient: _____

I hereby authorize release of information necessary to file a claim with my insurance company/companies. I assign benefits to be paid to *Children's Orthotics and Prosthetics* and I understand that I am financially responsible for charges for medical devices provided by *Children's Orthotics and Prosthetics* to the above-named patient, regardless of insurance coverage.

Signature of patient's parent or authorized guardian: _____

Print Name: _____

Relationship to Patient: _____ Date: _____

How did you find us:

- ◯ *Google*
- ◯ *Friend*
- ◯ *Referred from physician*
- ◯ *Referred from therapist*
- ◯ *Family*
- ◯ *Other*

AUTHORIZATION TO RELEASE MEDICAL RECORDS

(This authorization complies with HIPAA)

Printed Name of Patient (first, middle, last name)	Birthdate (mm/dd/yyyy)
Address (Street Address, City, State, Zip Code)	
Phone Number	E-mail

Printed Name of Guardian or Legal Representative (first, middle, last name)	
Address (Street Address, City, State, Zip Code)	
Phone Number	E-mail

The following person/organization is hereby authorized to receive my entire medical record, treatment record and diagnostic record.

Person/Organization to Receive Information Children's Orthotics and Prosthetics		
Street Address 810 South Durango Drive, STE 100		
City Las Vegas	State NV	Zip Code 89145
Phone Number 702-932-1300	Fax Number 702-848-4990	

By my signature below, I acknowledge that any prior agreement I have made to restrict or limit the disclosure of information about my health does not apply to this authorization.

I understand and agree that health information about me, which is used or disclosed pursuant to this authorization, may be subject to re-disclosure by the recipient and may no longer be protected by law.

This authorization is valid for 24 months following the date of my signature shown below. A copy, electronic copy, image, or facsimile of this authorization is as valid as the original. I have the right to revoke this authorization in writing at any time. I acknowledge that such a revocation is not effective to the extent the above person/organization has relied on the use or disclosure of my health information.

I have read (or have had read to me) this authorization, and I agree to its terms as indicated by my signature below. I am entitled to a copy of this authorization.

Signature of Patient or Personal Representative:	Date Signed:

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ACKNOWLEDGMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES

I am a parent or legal guardian of (patient name): _____
I have received a copy of Children's Orthotics and Prosthetics Notice of Privacy Practices effective September 1st, 2017.

Name (please print): _____
Relationship to Patient: ☐ Parent ☐ Legal Guardian
Signature: _____
Date: _____