Tierney Orthotics and Prosthetics
1345 Westgate Center Drive, Suite B | Winston Salem, NC 27103 | (336) 546-7165 | Fax (866) 403-2483

Patient Registration

Patient's Name ____ Birthdate ______________
Last First M.I.

Street Address ____ ☐ Male ☐ Female

City ______________________________ State __________ ZIP ________________

Phone (_____) ______________ Cell Phone (_____) _______________ Email Address ________________________

Responsible Party ☐ Same as above / Patient ☐ Parent/Guardian ☐ Spouse ☐ Other______________

If not Patient- Name ____

Street Address ____

City ______________________________________ State __________ ZIP ________________

Phone (_____) ______________ Cell Phone (_____) _______________ Email Address ________________________

Please provide all insurance cards to the front desk. We will make copies and return cards to you before you leave.

Is this injury/illness work related? ☐ Yes ☐ No If yes, Date of injury or onset of illness: ___________________

Workers Compensation Claim No. __________________________ Claim Adjuster___________________________

Referring Doctor:

Name ____ Phone (________) ____________________

Primary Care Doctor (if different from referring):

Name ____ Phone (________) ____________________

Do you have diabetes? ☐ Yes ☐ No If Yes, which doctor is treating you for diabetes?

Name ____ Phone (________) ____________________

I acknowledge, to the best of my ability, that the above information is up to date and accurate.

Signature ____ Date ____________________

Tierney Orthotics and Prosthetics, Inc.
1345 Westgate Center Drive, Suite B
Winston-Salem NC 27103
Phone: 336-546-7165 Medical Records Fax: 888-247-3689

Authorization to Release Medical Information

Patient Name ______________________________ Date of Birth ________________
Address ______________________________ Phone ____________________
City ______________________________ State __________ Zip __________

I authorize the release of the following protected health information:
Please check box and specify a physician, if any, or simply write ALL in the line provided

☐ Office Notes/Name of Physician ______________________________ Dates __________

☐ Radiology Reports ______________________________ Dates __________

☐ Other ______________________________ Dates __________

The purpose for this request to release medical information is:

☐ Medical Care / Treatment ☐ Insurance

Send my medical information to:

Tierney Orthotics and Prosthetics
Address: 1345 Westgate Center Drive, Suite B
Winston Salem, NC 27103

Fax: 888-247-3689

I understand that

- By signing this form, I am authorizing the use or disclosure of protected health information as indicated above.
- I may revoke this authorization at any time, before the information I have requested is released, by providing written notice of revocation (as specified in the Notice of Privacy Practices).
- A copy of this signed form will be provided to me, upon request.
- This authorization expires on ___/___/___ (if date not completed / one year after signed).

______________________________ ______________________________
Patient / Representative Signature Date

If the patient listed above is a minor or is unable to sign and you are a parent, legal guardian, or personal representative signing on behalf of this patient, please sign above and complete the following:

______________________________ ______________________________
Print Name Relationship to patient

1345 Westgate Center Dr, Ste B,
Winston Salem, NC 27103
Tel: 336-546-7165 Fax: 866-403-2483

Acknowledgement of Financial Responsibility

Since complete verification of my Durable Medical Equipment Prosthetic Orthotic Supplies (DMEPOS) coverage cannot be made at this time, I agree to pay for all services I receive from the providers of this practice should my insurance company refuse to pay for my care.

Should my insurance carrier refuse payment (e.g. non-covered services, no benefits for billed service, etc), I will pay for all services rendered upon receiving a written and/or verbal notice of the denial of my claim. Failure to pay within 90 days of our initial filing is, for the purpose of this agreement, a refusal to pay.

I further agree and understand that this office only can code and file a claim for my devices with the diagnosis that was provided and documented in medical records by your referring physician. Thus, to ask this office to request a diagnosis change from your referring physician solely for the purpose of securing reimbursement from an insurance carrier is inappropriate and fraudulent.

In the event that I do not pay for these, or any, services provided to me when due, I agree to pay all costs associated with collection, including reasonable attorney's fees as part of the collection process.

Any refund due to me because of overpayment at the time of service will be distributed 30-45 days after the insurance has paid their portion of the claim.

Custom items CANNOT be canceled once the order is placed.

Off the shelf items that have been canceled after supplies are ordered are subject to a restocking fee + return shipping cost. Some off the shelf items CANNOT be returned and full cost will be due to you if the order is canceled after it is placed.

By my signature, I certify to having read the above statement and fully understanding my financial responsibility for all services provided to me by Tierney Orthotics and Prosthetics for as long as I am a patient, regardless of changes to my insurance coverage.

_______________________________________ _______________

Patient Name (or responsible party if minor) Date

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Patient Signature (or responsible party if minor)