

# Mutual Orthopedics Co., Inc.

State of the Art in Orthotics and Prosthetics

1767-42 Veterans Memorial HWY  
Islandia, NY 11749  
(631) 265-4444  
Fax (631) 265-4580

[www.mutualortho.com](http://www.mutualortho.com)

702-704 8th Avenue  
Brooklyn, NY 11215  
(718) 499-4535  
Fax (718) 499-5230

PATIENT \_\_\_\_\_ GENDER M / F \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

PHONE \_\_\_\_\_ ALT. PHONE \_\_\_\_\_

D.O.B \_\_\_\_\_ EMAIL: \_\_\_\_\_

PRIMARY INSURANCE \_\_\_\_\_ ID# \_\_\_\_\_

SECONDARY INSURANCE \_\_\_\_\_ ID# \_\_\_\_\_

PRESCRIBING DOCTOR \_\_\_\_\_

OFFICE NUMBER \_\_\_\_\_

LOCATION SEEN: \_\_\_\_\_

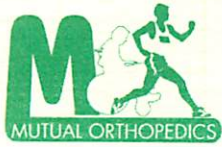
DIAGNOSIS: 1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_ 4) \_\_\_\_\_

### DISCLAIMER-PLEASE READ CAREFULLY!

If my health insurance company denies payment, I agree to be personally and fully responsible for payment. I also understand that if my health insurance company does make payment for services, I will be responsible for any co-payment, or deductible, coinsurance that applies. \_\_\_\_\_(INITIALS)

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

*Certified Prosthetic and Orthopedic Appliance Facility*



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## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I certify that I have received a copy of Mutual Orthopedics Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that may occur in my treatment, payment of my claim(s) and/or invoice(s), and in the performance of Mutual Orthopedics healthcare operations. The Notice also describes my rights and Mutual Orthopedics duties with respect to my protected health information. The Notice is posted in the reception area.

Mutual Orthopedics reserves the right to change the privacy practices that are described in the Notice. I may obtain a revised copy by calling the office and can also request a copy to be sent in the mail or by asking for a one at my next appointment.

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Signature of Patient or Personal Representative

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Name of Patient or Personal Representative

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Date

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Description of Personal Representative's Authority