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

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. _____(INTIALS)

PATIENT SIGNATURE_____ DATE_____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICS

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.

_____

Signature of Patient or Personal Representative

_____

Name of Patient or Personal Representative

_____

Date

_____

Description of Personal Representative's Authority