Demographics:

First:

Last:

Gender:

Birthdate:

Address 1:

Address 2:

City: State/Province:

Zip Code/Postal Code :

Insurance Information

Insurance/Member Id Number:

Insured Name:

Company:

Policy/Group Number:

Insurance Provider Phone:

Insured Birthdate:

Patient's Relation to Insured:

Contact Information

Preferred Contact Method:

Email Address:

Additional Information

1. Do you have a Medicare Advantage Plan or Replacement Plan?
2. Is this a Worker's Compensation Claim?
3. Is this visit accident related?
4. What is the name of the physician who referred you to A Step Ahead and date last seen by them (Must be within 6 months)?
5. Are you in Physical or Occupational Therapy anywhere?
6. What is the therapist's name and facility you are seen at?
7. If the patient is unable to sign, please list the reason why or type N/A:
8. If you are an authorized representative of the patient, please type your name below:
9. If you are an authorized representative of the patient, what is your authority to sign on behalf of the patient?
10. What is your current living status?

11. Is there anything additional you would like us to know?

Financial Agreement & Assignment of Benefits:

Financial Agreement & Assignment of Benefits:
Thank you for choosing A Step Ahead Orthotics and Prosthetics as your provider. Please take a moment to read the following and sign the bottom of this form.
If applicable, insurance balances are ultimately the patient's obligation. We will file most primary insurances at no cost to you as a courtesy. However, insurance balances that are not paid may be billed to you. Please keep statements and follow-up with your insurance carrier to ensure prompt payment. Some of your treatment may not be covered by your insurance carrier. The cost for such charges will be your responsibility. There will be a minimum fee of $30 for any checks returned as Non-Sufficient Funds (NSF). Patients are asked to confirm their appointments at least 24 hours in advance by directly contacting our office or by responding to our confirmation contact. ***Arriving more than 15minutes late for your appointment may result in having to reschedule.*** We understand situations arise but please know you are taking up

someone else's designated time. I understand that and agree to be responsible for payment for all services rendered on my behalf or my dependents' behalf. I have been given the opportunity to pay my estimateddeductible and coinsurance at the time of service. I have chosen to assign benefits, knowing that the claim must be paid within all state and federal prompt payment guidelines. I also understand that should my insurance company send payment to me; I will forward the payment to A Step Ahead within 48 hours. I understand and agree to notify A Step Ahead upon change of insurance any time during my care so the correct insurance can be filed. I also understand that insurances quotes given are an estimate only and I will be responsible for charges not covered and agree to pay all costs. I authorize A Step Ahead O & P to obtain/release any medical records needed by another medical provider. I authorize A Step Ahead P & P to initiate a complaint or file an appeal to the insurance commissioner or any payer for any reason on my behalf and I will personally be active in the resolution of claims delay or unjustified denials.

Signature: _____

HIPAA & Notice of Privacy Practices:

Your Information. Your Rights. Our Responsibilities.
This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights:

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.
Get an electronic or paper copy of your medical record. • You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record. • You can ask us to correct health information about you that is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications. • You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share. • You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a copy of this privacy notice. • You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you. • If you have given someone medical power of attorney or if someone is your legal
guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated.
• You can complain if you feel we have violated your rights by contacting us using the information listed below. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave, S.W., Washington, D.C. 2021, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/ • We will not retaliate against you for filing a complaint.

Your Choices:

For certain health information, you can tell us your choices about what we share.
If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choices to tell us to:
• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory. *If you are not able to tell us your preference, for example, if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health and safety.* In these cases, we never share your information unless you give us written permission: • Marketing purposes • Sale of your information

Our Uses and Disclosures:

How do we typically use or share your health information?
We typically use or share your health information in the following ways:
Treat you:
We can use your health information and share it with other professionals who are treating you. *Example: A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization:
We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.
Bill for your services:
We can use and share your health information to bill and get payment from health plans or other entities. *Example: We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information?
We are allowed or required to share your information in other ways - usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information, see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.
Comply with the law:
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Address workers' compensation, law enforcement, and other government requests:
We can use or share health information about you: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions, such as military, national security, and presidential protective services
Respond to lawsuits and legal actions:
We can share health information about you in response to a court or administrative order, or in response to a subpoena.
Our Responsibilities:
• We are required by law to maintain the privacy and security of your protected health information. • We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. • We must follow the duties and privacy practices described in this notice and give you a copy of it. • We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/ noticepp.html.

Signature:_____