CUNNINGHAM PROSTHETIC CARE
PERSONAL INNOVATIVE PROSTHETIC AND ORTHOTIC CARE

Today's Date: _____

PATIENT INFORMATION

_____ _____ _____
Name (Last, first, middle initial) Gender Social Security Number

_____ _____
Street address City State Zip Date of Birth

_____ _____ _____
Home phone Cell phone Email address

_____ _____ _____
Emergency Contact Relation to patient Phone Number

_____ _____ _____
Employer (or Retired, Disabled, etc.) Address Phone Number

Height: _____ Weight: _____ Recent change?: _____ Overall Pain Score (10 is worst) _____

_____ _____ _____
Primary Insurance Secondary Insurance Tertiary Insurance

_____ _____ _____
Referring Physician Primary Care Provider How did you hear about us?

Are there any questions you'd like answered today? _____

CONSENT TO TREAT, ASSIGNMENT OF BENEFITS, PATIENT RESPONSIBILITY FOR PAYMENT AND REQUIRED FORMS I, the undersigned, being either the patient or the patient's legally authorized representative, do hereby:

- Consent to medical treatment and/or evaluation, including but not limited to laboratory and x-ray examinations, and minor in office procedures.
- Assign all benefits under any insurance or health benefit plan for payment for medical services rendered by Jerald Cunningham, CPO to Cunningham Prosthetic Care.
- Accept financial responsibility for any amount not paid by insurance or other health benefit plans in accordance with Cunningham Prosthetic Care's "Patient Financial Policy".
- I acknowledge that I have received a copy of the "Patient Financial Policy / Patient Rights and Responsibilities" and a copy of the Cunningham Prosthetic Care's "Notice of Privacy Practices".
- Release of Medical Information. I hereby authorize my Provider, Cunningham Prosthetic Care, to release any information necessary for my course of treatment. I am aware of my HIPAA Rights. I further authorize Cunningham Prosthetic Care to request information necessary for my treatment from other members of my health care team.
- Agree to the use of my photographic or videographic image for business and educational purposes.

I understand that it is my responsibility to read the information, and ask any questions that I may have. I further understand that current copies of both documents will be available at all times for my review. I understand this document remains in effect for as long as I continue to visit Cunningham Prosthetic Care, unless specifically rescinded in writing.

_____ _____ (or) _____ _____
Patient Signature Date Legally Authorized Representative Date

For legally Authorized Representative ONLY: Relationship/ reason for representative: ◯ Minor Patient ◯ POA

(provide copy of POA documents) persons authorized to accompany and make treatment decisions for the patient

_____ _____ _____ _____
Name/Relation Name/Relation