NEW PATIENT INFORMATION

This Section is for Office Use: Date: ________________ Patient #: ________________

PATIENT INFORMATION

Patient's First Name	M.I.	Last Name	Date of Birth	Social Security
Street Address	City	State	Zip Code	Gender ☐ M ☐ F
Phone 1	Phone 2	Email		Marital Status ☐ S ☐ M ☐ D

EMERGENCY/GUARDIAN CONTACT INFORMATION

Contact 1 First Name	M.I.	Last Name	Relationship to Patient ☐Self ☐Spouse ☐Parent ☐Guardian
Phone		Email	
Contact 2 First Name	M.I.	Last Name	Relationship to Patient ☐Self ☐Spouse ☐Parent ☐Guardian
Phone		Email	

PRIMARY INSURANCE INFORMATION *(required)*

Name of Insurance Company			Insurance Phone
Member ID #	Group #		Plan #
Insured's Name *(if not the patient)*	Insured's Date of Birth	Insured's Social Security	Relationship to Patient ☐Self ☐Spouse ☐Parent ☐Guardian
Adjuster's Name	Phone	Email	Fax
Nurse/Case Manager's Name	Phone	Email	Fax

SECONDARY INSURANCE INFORMATION *(complete this section if you have additional insurance coverage)*

Name of Insurance Company			Insurance Phone
Member ID #	Group #		Plan #
Insured's Name *(if not the patient)*	Insured's Date of Birth	Insured's Social Security	Relationship to Patient ☐Self ☐Spouse ☐Parent ☐Guardian
Adjuster's Name	Phone	Email	Fax
Nurse/Case Manager's Name	Phone	Email	Fax

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NEW PATIENT INFORMATION

This Section is for Office Use: Date: ________________ Patient #: ________________

OTHER INSURANCE INFORMATION *(complete this section if you have additional insurance coverage)*

Name of Insurance Company			Insurance Phone
Member ID #	Group #		Plan #
Insured's Name *(if not the patient)*	Insured's Date of Birth	Insured's Social Security	Relationship to Patient ☐Self ☐Spouse ☐ Parent ☐Guardian
Adjuster's Name	Phone	Email	Fax
Nurse/Case Manager's Name	Phone	Email	Fax

IF NOT INSURED

Self Pay: ☐ Credit Card ☐ Payment Plan ☐ Check	Other:

HEALTH CARE PROVIDERS

List all heath care providers including physicians, specialists, clinicians, physical and occupational therapists, prosthetists and othotists so we may contact them to obtain patient's medical background/history and any other information that will help us process your claim.

Name 1	Specialty	Clinic
Address	Phone	Fax
Name 2	Specialty	Clinic
Address	Phone	Fax
Name 3	Specialty	Clinic
Address	Phone	Fax
Name 4	Specialty	Clinic
Address	Phone	Fax
Name 5	Specialty	Clinic
Address	Phone	Fax
Name 6	Specialty	Clinic
Address	Phone	Fax

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NEW PATIENT INFORMATION

This Section is for Office Use: Date: ________________ Patient #: ________________

INJURY ILLNESS INFORMATION

Type of Illness/Injury

- ☐ Chronic Pain
- ☐ Spinal Cord Injury
- ☐ Traumatic Brain Injury
- ☐ Cerebral Palsy
- ☐ Stroke
- ☐ Multiple Sclerosis
- ☐ Brachial Plexus Injury
- ☐ Hemispherectomy
- ☐ Muscular Dystrophy
- ☐ ALS
- ☐ Other: ________________________

Date of Injury or Onset of Illness/Symptoms	Is Injury/Illness the Result of an Accident? *(select all that apply)* ☐ Work-related ☐ Auto ☐ Other:	State Where Accident Occurred

EMPLOYMENT INFORMATION *(fill out only if injury/illness was work-related)*

Name of Employer	Employment Status ☐ Full-time ☐ Part-time ☐ Retired ☐ Unemployed ☐ Student ☐ Other

DEVICE INFORMATION

What type of AxioBionics Device are you interested in?

- ☐ Wearable Therapy®
- ☐ TripleFlex™
- ☐ WalkAide®/Pace FES
- ☐ Orthotics

Where did you hear about us?

- ☐ Doctor
- ☐ Therapist
- ☐ Orthotist/Prosthetist
- ☐ Website (Web Search)
- ☐ Facebook
- ☐ Twitter
- ☐ Other:

EXISTING MEDICAL CONDITIONS

Condition			Condition		
Cancer	☐ YES	☐ NO	Heart Condition	☐ YES	☐ NO
In remission?	☐ YES	☐ NO	Cardiac Demand Pacemaker	☐ YES	☐ NO
Seizure Disorder	☐ YES	☐ NO	Manufacturer:	Model:	
On Anti-seizure Medications?	☐ YES	☐ NO	Phone:		
Seizures under control?	☐ YES	☐ NO	Cardiac Defibrillator	☐ YES	☐ NO
Brain Impairments	☐ YES	☐ NO	Manufacturer:	Model:	
Varicose Veins	☐ YES	☐ NO	Phone:		
Allergies to Adhesives	☐ YES	☐ NO	Metal Implants in the body	☐ YES	☐ NO
Blood Clots	☐ YES	☐ NO	Location:		
Diabetes	☐ YES	☐ NO	Other Medical Conditions	☐ YES	☐ NO

Describe all conditions for which you checked YES, and any others not listed:

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NEW PATIENT INFORMATION

This Section is for Office Use: Date: ________________ Patient #: ________________

PRIMARY INSURANCE INFORMATION

I authorize AxioBionics to release any medical or other information about me to my other healthcare providers or any other party for the purposes of treatment, payment, or healthcare operations; to my insurance company, health benefit plan, federal health benefits program, third-party payer, third-party administrator, or any other party, including any billing and/or collection service utilized by AxioBionics, necessary to process an insurance claim and/or to invoice and collect payment for items/services provided by AxioBionics and to release any medical or other information about me to auditors authorized by AxioBionics for the purpose of certification, licensure and accreditation, audit and/or review. I permit a copy of this authorization to be used in place of the original. I further authorize AxioBionics to contact me via telephone regarding services to be provided to me.

ASSIGNMENT OF INSURANCE BENEFITS

I certify that the information given by me is correct. I request that payment for authorized benefits are made on my behalf, I assign the benefits payable for covered services rendered by AxioBionics and authorize AxioBionics to submit claims to Medicare, Medicaid and/or commercial insurance carries, other third-party payers, and administrators for payment. I authorize payment of my benefits directly to AxioBionics.

PAYMENT POLICY AND RESPONSIBILITY FOR PAYMENT

I understand that it is my responsibility to know my insurance benefits and coverage for all durable medical equipment, supplies and services provided to me by AxioBionics. I understand that AxioBionics, as a courtesy to me, will make every reasonable effort to bill all of my insurance companies for payment of my account. I understand that my insurance does not pay for everything and may not pay for the services or products (including durable medical equipment supplies) provided by AxioBionics. I understand that any remaining balance is my responsibility. I further agree to be personally and fully responsible for all items and services provided by AxioBionics that my insurance will not pay for and any deductibles and/or co-payments to the fullest extent allowed by law and my health benefits plan. If AxioBionics determines that insurance coverage is not available, I understand I that am responsible for all costs.

In the event that I fail to make a payment for which I am personally liable within thirty (30) days after invoice from AxioBionics, I understand that AxioBionics will charge interest on the outstanding balance at the rate of 1.5% per month until the outstanding balance is paid in full. I understand that payment may be made by cash, check, Visa, MasterCard, or American Express and I am responsible for making payment arrangements with AxioBionics if payment cannot be made in full upon receipt of the invoice. I further agree that in the event that any account is placed with an outside collection agency due to nonpayment, I will be responsible for any collection fees that may be added to my outstanding balance. I also understand that a $135.00 office visit charge will be added to my account should I decide to cancel a service/device after casts, molds, or measurements have been made. I agree to pay this charge in the event it is incurred.

I understand that the products made by AxioBionics are custom-made or custom-fit and include a significant degree of professional service that render the products non-returnable. I understand that all sales are final and no refunds will be issued for any reason. Fitting devices such as prosthetics, orthotics, and neuroprosthetic devices to the human body may require making adjustments on an individual basis to ensure proper fit, maximize benefit and function, and ensure safety of use. AxioBionics is committed to this process and, as such, adjustments to fit and performance are included in the AxioBionics one-year warranty.

PATIENT ACKNOWLEDGEMENTS

1. I certify that I have received a copy of the AxioBionics Privacy Practices.
2. I am aware that I have a condition which requires orthotic and/or prosthetic treatment by AxioBionics. I understand that my physician has ordered this item/service as part of my treatment and that I am under his/her supervision.
3. I am also aware and acknowledge that representatives of AxioBionics have made no guarantees to me regarding the results of any examination or treatment.
4. I understand that multiple visits may be required to achieve proper fit and/or desired results.
5. I have read this authorization form, or it has been read to me, and I understand its contents and agree to its terms.
6. I have completed this form fully and accurately, and have been given the opportunity to ask questions about this form and the services and products that may be provided.
7. I am competent and able to make decisions concerning the services and products that may be provided.

Patient's Signature	Print Name	Date
Authorized Representative's Signature	Print Name	Date
Authorized Representative's Relationship to Patient:		