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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Axio Bionics®

NEW PATIENT INFORMATION

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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

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:

continued on next page

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.

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 $35.00 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.

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 have read this authorization form or this authorization form has been read to me, and I understand its contents and agree to its terms.
5. 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.
6. 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
Relationship to Patient:		