Inland Artificial Limb & Brace, Inc.

Your Premier Choice for Orthotic and Prosthetic Services

Patient Information

Patient Name: _____
First Name M.I. Last Name

Date of Birth: _____ Social Security #: _____

Home Address: _____ Apt. No.: _____

City: _____ State: _____ Zip: _____

Home Number: _____ Cell Number: _____

Email Address: _____

Marital Status: Married Single Divorced Widowed Minor

Referral/Insurance Information

Referring Physician: _____ Primary Care Physician: _____

Primary Insurance: _____ Secondary Insurance: _____

How do you intend to pay for your portion? Cash Check Credit Card Care Credit

Diagnosis/Nature of Injury: _____ Date of Onset: _____

Is the injury related to: Work Auto Other Accident Non-Accident

Insurance Subscriber Details

Subscriber Name: _____ Date of Birth: _____

Subscriber Address: _____

_____ _____

Signature of Patient or Parent and/or Guardian **Date**

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Financial Policy

Managed Care/Medi-Cal Patients:
Although you may have received an authorization from your medical group this may not be a guarantee of coverage/payment under your health plan. Prior approval from your Managed Care Payor will be required prior to rendering services. Be aware that Managed Care benefits differ from carrier to carrier. You may be responsible for office visit co-pays, deductibles, and share of costs to be paid in full at the time of service. Please be aware that some, and perhaps all, of these services, which may be provided, may be non-covered services by your health plan, in which case, payments for these services will be your responsibility.

Private Insurance/Medicare Patients:
We may accept assignment for services exceeding $250.00 pending review of your primary insurance coverage. We may elect not to accept assignment on supplemental insurance coverage. However, as a courtesy we will submit the bill to your supplemental insurance company on your behalf and if the insurance company pays the bill, they will send the payment directly to you.

The balance due is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please be aware that some, and perhaps all, of the services may be non-covered services and not considered reasonable and/or necessary under the Medicare Program and/or other medical insurance plans.

Usual and Customary:
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment of charges at our customary rates regardless of any insurance company determination of usual and customary rates.

Minor Patients:
The adult accompanying a minor and the parents (or guardians of the minor) is responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized or payment is made in full at the time of services.

Thank you for understanding our financial policy. I have read the Assignment of Benefits/Authorization for Release of Information, Insurance Disclaimer, and Financial Policy and I understand and agree to the policies.

_____ _____

Signature of Patient or Parent and/or Guardian **Date**

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Name of Patient: _____

HICN or Insurance Id #: _____

Assignment of Benefits/Authorization for Release of Information

I request that payment of authorized Medicare, Medicaid, or private insurance benefits be made to Inland Artificial Limb & Brace for any covered services furnished to me by Inland Artificial Limb & Brace. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents, Champus and its agents, or to any private insurance company any information needed to determine these benefits or the benefits payable for related services. If this is a private insurance claim, I further agree to be responsible for all the full amount of the charges from the date of delivery if my private insurance company does not pay for the charges in a timely manner, or my physician or I fail to provide within thirty (30) days the information necessary to submit the claim for payment.

Insurance Disclaimer

Inland Artificial Limb & Brace is an Orthotic, Prosthetic, & Durable Medical Equipment Provider. In order to provide all our patients with adequate care it is important for us to inform you that all payments from your insurance are based on the terms of your coverage. These terms typically include certain exclusions, limitations, and other conditions. Inland Artificial Limb & Brace has no way of knowing what those terms may be, and is in no way responsible for knowing. Please be advised that even with a Doctor's Prescription, or Authorization from your medical group, this in NO WAY guarantees full coverage for the services provided to you by Inland Artificial Limb & Brace. By signing this disclaimer you are agreeing to pay for any unpaid balances by your insurance group such as, co-payments, deductibles, and non-covered expenses. Again, Inland Artificial Limb & Brace takes no responsibility in knowing your medical coverage.

If you have questions regarding your Durable Medical Equipment coverage please refer to your Insurance Handbook or call the customer service number listed on the insurance card. Thank you for your attention to this matter.

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