Master's LLC
Orthotics & Prosthetics

9975 Mickelberry Rd NW, Silverdale, WA 98383-8531
(360) 307-7005 • Fax (360) 698-1984

CLIENT REGISTRATION *(PLEASE PRINT)*

Client's Last Name	First	Middle

Address: Street	Address: Mailing (if different)

City	State	Zip	City	State	Zip

Date of Birth	Sex	Social Security #
	☐ M ☐ F	

Home Phone	Cell Phone	Consent to text?	Leave Detailed Messages?
		☐ Yes ☐ No	☐ Yes ☐ No

Spouse or Parent's Name

Client's Employer	Phone	Email

Primary Care Physician	Referring Physician	Name, Social Security # and Date of Birth of Person Responsible for Payment

WHO SHOULD BE NOTIFIED IN CASE OF EMERGENCY? PLEASE INCLUDE NUMBER NOT LISTED ABOVE.

Name	Phone	Relationship to Client	Permission to share medical info?
			☐ Yes ☐ No

INJURY INFORMATION

Diagnosis Left Right	Date of Injury	Cause of Injury — what happened and where. Is anyone else liable?

On-the-job injury?	If yes, name of employer at time of injury.	Claim Number	State L&I / Name of Self-Insured
☐ Yes ☐ No			

HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING?

Hepatitis: A, B or C	MRSA	Pulmonary disease (TB)	HIV
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

OTHER CONDITIONS

Currently pregnant?	Known allergies/other conditions
☐ Yes ☐ No	

PRIMARY INSURANCE INFORMATION *SECONDARY*

Insurance Name	ID#	Insurance Name	ID#

Subscriber's Name	Group#	Subscriber's Name	Group#

PLEASE READ AND SIGN

OFFICE BILLING POLICY: Master's Orthotics and Prosthetics accepts Medicare assignment for all Medicare clients. Payment is expected at the time of service unless other arrangements have been made in advance. Exceptions to this include those insurance companies for which we are preferred or participating providers. We will bill those insurances for you, however, any co-payments or deductibles are due at the time of service. All outstanding accounts will have a .75% rebilling fee added after 30 days. You may be held liable for additional costs incurred during the collection process.

RETURN POLICY: Due to health regulations, products provided by Master's Orthotics and Prosthetics may not be returned for refund, credit, or exchange unless the product is covered under the manufacturer's product quality warranty.

RELEASE OF INSURANCE BENEFITS AND MEDICAL INFORMATION: I authorize my insurance benefits to be paid directly to Master's Orthotics and Prosthetics. I am financially responsible for any balance due and also for all court fees, attorney fees, and all other fees necessary to collect this account. I authorize the release of any medical information necessary to process this claim. I understand that my protected health information may be used by Master's Orthotics and Prosthetics to provide treatment, obtain payment, and perform health care operations.

I authorize services to be performed by Master's Orthotics and Prosthetics as prescribed by my physician. By signing below, I acknowledge and agree to the statements above and those listed on the back of this form.

Signature: _____

Date: _____

Client Bill of Rights and Responsibilities

I have received and understand the rights and responsibilities afforded me as a client of Master's Orthotics and Prosthetics.

Initials:_____.

Acknowledgement of Receipt of Privacy Practices

I certify that I have received a copy of Master's Orthotics and Prosthetics' Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills, or in the performance of Master's Orthotics and Prosthetics' health care operations. The Notice of Privacy Practices also describes my rights and Master's Orthotics and Prosthetics' duties with respect to my protected health information. The Notice of Privacy Practices is posted in the reception area.

Master's Orthotics and Prosthetics reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Initials:_____.

Medicare Supplier Standards

I have received and understand the Medicare Supplier Standards upheld by Master's Orthotics and Prosthetics.

Initials:_____.

Same or Similar

Have you received the same or similar item prescribed by your physician within the last five years?

☐ Yes ☐ No

If so, when did you receive it, where and from what facility did you get it, did Medicare pay for it, and why is a duplicate necessary.

Initials:_____.

Insurance Clients

I understand that my insurance company will make determination of medical necessity after a claim for services has been submitted. If my insurance determines not to be medically necessary, or if the services are a non-covered benefit, I agree to be personally and fully responsible for complete payment of these services prescribed by my physician and provided by Master's Orthotics and Prosthetics. I understand this information and all my questions were answered to my satisfaction.

Initials:_____.