Certified Pedorthic Orthotics

1901 Blanding St
Columbia, SC 29201

Please Complete All Sections of This Form

Date: _____

First Name: _____Middle Initial:____ Last Name: _____

Date of Birth: _____ Sex: _____ Ht: _____ Wt: _____ Marital Status: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____ SSN #: _____

Cell Phone #: _____Home Phone #: _____

Are you diabetic? _____

Are you currently in a nursing facility? _____ If yes, where? _____

Are you currently receiving Home Health? _____ Are you currently employed? _____

Authorization to treat and/or discuss treatment, results, and procedures.
This allows others (grandparents, aunts, uncles, etc.) to bring child into office and/or receive results or follow-up instructions

I, _____ authorize the following people:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

AUTHORIZATION TO PAY BENEFITS: I hereby authorize payment directly to the Servicing facility and/or Medical Benefits, if any, payable to me for his/her services as described, realizing I am responsible to pay any deductible, out-of-pocket, and/or non-covered services.

Signature: _____ Date: _____

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Physician to release any information related to my treatment necessary to provide proper care and billing.

Signature: _____ Date: _____

CERTIFIED PEDORTHIC ORTHOTICS
1901 BLANDING STREET
COLUMBIA, SC 29201
(803) 779-0550

NOTICE OF PRIVACY PRACTICES

The purpose of the Notice of Privacy practices is to assist you in understanding what is in your medical record and who, what, when where and why others may have the right to use your health information. This document will assist you in making more informed decisions when authorizing disclosures of your health information. Certified Pedorthic Orthotics is committed to protecting your personal health information (PHI) in compliance with federal law.

The Privacy Practice states:

- Our obligations under the law with respect to your personal health information.
- How we may use the health information that we keep about you.
- Your rights relating to your personal health information.
- Our rights to change our Notice of Privacy Practices.
- How to file a complaint if you believe your privacy rights have been violated.
- The conditions that apply to uses not described in this Notice.
- The person to contact for further information about our privacy practices.

We are required by federal law to give you a copy of this Notice and to obtain your written acknowledgment that you have received a copy of this notice.

I, hereby acknowledge that I have received a copy of the Notice of Privacy Practice.

_____	_____
Patient Signature	Date
_____	_____
Signature of Patient's Representative	Date
_____	_____
Compliance Office	Date