PORTLAND OFFICE:
8605 SW Terwilliger Blvd
Portland, OR 97219
Ph:(503)478-0600
Fx:(503)478-0602

SALEM OFFICE:
744 Hawthorne Ave NE
Salem, OR 97301
Ph:(503)798-4988
Fx:(503)798-4989

PATIENT REGISTRATION FORM

PATIENT NAME:		DATE OF BIRTH:		SEX:	M
PATIENT ADDRESS:					
CITY/STATE/ZIP:					
HOME PHONE:		CELL PHONE:			
PARENT/GUARDIAN NAME					

INSURANCE INFORMATION

PRIMARY INSURANCE				COPY OF CARD: ☐
ID NUMBER		GROUP NUMBER		

SECONDARY INSURANCE				COPY OF CARD: ☐
ID NUMBER		GROUP NUMBER		

AUTHORIZATION OF SERVICES:
I authorize A STEP FORWARD, LLC to release information related to this bill for services to my insurance company. I authorize release to the social security administration or health care, financing administrator and/or its carriers any information needed for this or related medical claim. I authorize direct payment of medical benefits to A STEP FORWARD, LLC for these services. I understand that I am financially responsible for charges not covered by my insurance plan.

FINANCIAL POLICY:
As a courtesy, we will bill your insurance. The services provided by A STEP FORWARD, LLC may not be covered by your insurance carrier. I understand that I am responsible for all charges whether or not covered by insurance. If preauthorization is required by my insurance carrier, and I choose to receive services before authorization is obtained, I understand that I will be solely responsible for any charges not approved by my insurance carrier. If the patient is covered under a medicaid plan the patient is responsible for payment of services that are not covered by the medicaid plan. In the event that the patient does not wish to return for the final fitting of a custom device, the patients insurance will be billed for work completed and the patient will be responsible for any balance and cost incurred.

WARRANTY POLICY:
Custom devices are fully guaranteed under normal use for 90 days and A STEP FORWARD, LLC will make any repairs to the device, as needed, and free of charge during the warranty period. This does not apply to changes in physical weight, condition, nor any other physiological changes that may occur, or to any alterations made by anyone other than A STEP FORWARD, LLC. Off the shelf items are subject to manufacturers warranties.

CASH PAYMENT POLICY:
A STEP FORWARD, LLC offers a 15% discount on any custom fabricated device for which the patient wishes to be self pay for. Payment for self pay devices is due at the time of fitting and insurance will not be billed.

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES:

I have received a copy of A STEP FORWARD, LLC 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 and of my bills or in the performance of A STEP FORWARD, LLC health care operations. The Notice of Privacy Practices also describes my rights and A STEP FORWARD, LLC duties with respect to my protected health information. The Notice of Privacy Practices is posted in A STEP FORWARD, LLC reception area and it is also available on the website at *www.astepforwardpdx.com/*

A STEP FORWARD, LLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised copy of these practices by calling the office at 503-478-0600 and requesting a revised copy or accessing it on the A STEP FORWARD, LLC website.

COMPLAINTS:

Our goal at is to provide excellent service to our patients. If you have any problems with our services, please contact our office at 503-478-0600. A formal complaint can also be filed with our accreditation body, The American Board for Certification in Orhtotics, Prosthetics and Pedorthics.

MEDICARE ONLY:

I request that payment of authorized Medicare benefits to me or on my behalf for any services furnished me by or in A Step Forward, LLC. I authorize any holder of medical information about me to release to the CENTERS FOR MEDICARE AND MEDICAID SERVICES and its agents any information needed to determine these benefits or benefits for related services _________ (intl.)

I have received a copy of Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Supplier Standards_________(intl.)

I AGREE AND UNDERSTAND THE ABOVE STATEMENTS:

____ ____________________

(Signature of Patient or Designee) Date

____

Printed Name of Designee **and** Relationship to Patient