HENLEY MEDICAL PATIENT INFORMATION

Patient
Full Name:______________________
Date of Birth:______________________
Address:______________________
City/State/Zip:______________________
Phone: Home Work Cell:______________
Phone: Home Work Cell:______________
Diagnosis:______________________

Patient Primary Insurance
Company Name:______________________
Policyholder Name:______________________
Policyholder Date of Birth:____________
ID #: ______________________
Policyholder Address:______________________
____
Relationship to Patient:______________

Parent/Guardian/Spouse (Circle One)
Full Name:______________________
Address:______________________
City/State/Zip:______________________
Phone: Home Work Cell:______________
Phone: Home Work Cell:______________
Employer:______________________
Employer Phone:______________________

Patient Secondary Insurance
Company Name:______________________
Policyholder Name:______________________
Policyholder Date of Birth:____________
ID #:______________________
Policyholder Address:______________________
____
Relationship to Patient:______________

Primary Care Doctor:________________
Physical Therapist:________________

Orthopedic Doctor:________________
Height:__________Weight:__________

Any Past or Upcoming Surgeries:______________________________________
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EMERGENCY CONTACT (Required)
Name:______________________
Phone: Home Work Cell:______________

Acknowledgement of receipt of information:
Please initial the following in acknowledgement of receipt of information:
_______ I received written & verbal instruction of my Bill of Rights.
_______ I received written & verbal instruction for filing a grievance or complaint.
_______ I received written & verbal instruction regarding company policy for investigating & resolving complaints.
_______ I received written & verbal instruction of Henley Medical's Privacy Policy.
_______ I have received a copy of the DMEPOS Supplier Standards (if applicable)
_______ I have received a brochure describing the care & services Henley Medical provides.
_______ I have been provided with emergency preparedness and home safety information.
_______ I am aware that the Henley Medical new patient documentation is available on their website.

I hereby authorize Henley Medical to obtain and/or release any and all medical information including photographs of patient and/or equipment relating to all claims for benefits submitted on my behalf (and/or my dependents) to the above-named insurance carriers. I further expressly agree and acknowledge that my signature on this document authorizes the submission of claims for benefits, for services rendered or to be rendered, without obtaining my signature on each and every claim to be submitted, and that I will be bound by this signature as though the undersigned had personally signed the particular claim. This authorization remains valid and effective from the date of signing until revoked in writing. I have received a copy of and am in complete understanding of my rights and responsibilities as explained to me. I understand that I am financially responsible for all charges incurred, and that I am further responsible, whether or not I have insurance coverage, for prompt payment upon receipt of the bill. I have the right to review and obtain a copy of the Privacy Notice before signing. I also understand that the terms of the notice may change and I may obtain a copy of the revised Privacy Notice. I also understand that I as the patient have the right to restrict how Patient's Health Information is used or disclosed to carry out treatment of healthcare operations. Henley Medical is not required to agree to requested restrictions but if Henley Medical agrees to said restriction then it becomes binding. I understand that I have the right to revoke in writing the release of information with the exception of information already released. I understand that I have the Constitutional right to refuse medical services and/or treatment.

Signature______________________________ Date______________________________