CAPRO SOLUTIONS, LLC

CAPITAL ORTHOTIC PROSTHETIC ASSOCIATES

NAME: _____ D.O.B. _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE: _____ CELL: _____

NEXT OF KIN: _____ PHONE: _____

REASON FOR VISIT: _____

DATE OF AMPUTATION: _____ __above *or* __below knee &__RT *or* __LT

EMPLOYER: _____ PHONE: _____

REFERRING PHYSICIAN: _____ PHONE: _____

INSURANCE: _____ ID: _____

2ND INSURANCE: _____ ID: _____

AUTO ACCIDENT: YES / NO DOI: _____ WORKERS COMP: YES / NO DOI: _____

I understand that payment is due at the time of service. I understand that an original prescription is required to submit any claim for me to my insurance company. I will pay any co-pay and/or co-insurance that is due when services are rendered, and I further understand that my insurance may or may not cover all or any of the services provided. All expenses not covered by insurance is my personal responsibility and shall be paid in a timely manner. Any balance owed to CAPRO SOLUTIONS, LLC after 30 days will incur an interest charge of two percent (2%) per month. In the event of default, I will be responsible for any reasonable collection and/or attorney fees.

I hereby authorize any holder of medical or other information about me to release to CAPRO SOLUTIONS, LLC or its intermediaries or carriers any information needed to process healthcare claims for services rendered to me. I also permit a copy of this authorization to be used in place of the original, and request that payment under the healthcare program be made directly to CAPRO SOLUTIONS, LLC on any charges for services provided to me by that provider.

If at any time during my care by CAPRO SOLUTIONs, LLC, I change, cancel or modify my health insurance carrier, program or benefits, I will immediately notify CAPRO SOLUTIONS, LLC. Otherwise, I understand that I may be responsible to pay the entire amount of any charges for services rendered.

SIGNATURE: _____ **DATE:** _____

COPA
Capital Orthotic
Prosthetic Associates