YANKE BIONICS
Prosthetic & Orthotic Patient Care
Accept No Limitations

Patient Information

*Please have your **INSURANCE CARDS** and **PHOTO ID** available for copy*

Name _____

Home Phone (___) _____ Cell Phone (___) _____

Address _____ Work Phone (___) _____

_____ Employer Name _____

CITY STATE ZIP CODE Reside in Nursing Home? Y / N

Nursing Home Name _____

Email Address _____

Soc Sec # _____ Date of Birth _____ M / F

Height: _____ Weight: _____ Marital Status _____

Emergency Contact _____ Phone (___) _____

Relationship: Self Spouse Parent Child Other

Guarantor/Person Responsible for Patient (If under 18) _____

Relationship: Self Spouse Parent Child Other

Phone (___) _____ DOB _____ SSN _____

Address _____

CITY STATE ZIP CODE

Referring Physician _____ Phone (___) _____

Primary Physician _____ Phone (___) _____

Diabetic Physician (if applicable) _____ Phone (___) _____

Insurance Information

Primary Insurance _____ Policy Holder _____

Relationship _____ Date of Birth _____ SSN _____

Policy Holder Address _____

Secondary Insurance _____ Policy Holder _____

Policy Holder Address _____

Relationship _____ Date of Birth _____ SSN _____

Injury Information

Is your condition the result of an injury? Y / N Date of Injury _____

Describe Injury _____

Is your injury work related? Y / N Employer Name _____

Phone (___) _____ Address _____

Claim # _____ MCO _____

How did you hear about Yanke Bionics, Inc.? _____

_____ _____

PATIENT/GUARANTOR DATE

I certify that the above information is accurate and true

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PAYMENT POLICY, RELEASE OF INFORMATION AND ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We have prepared this explanation to help you understand our terms for payment of services rendered. Should you have any questions, please do not hesitate to call our office.

- **WHO IS RESPONSIBLE FOR PAYMENT OF MY BILL?** You are responsible for payment of our services. For your convenience, we accept Visa, Mastercard and Discover at no additional cost to you.
- **WILL YANKE BIONICS, INC. HELP ME WITH MY INSURANCE BILLING?** Yes, In the event that you have some type of Durable Medical Equipment coverage, we will assist you in obtaining payment for these services.
- **WHAT PORTION OF MY BILL WILL INSURANCE PAY?** I understand that my insurance contract defines to what extent the insurance company will make payments (refer to your major medical policy under durable medical equipment). As a rule, most insurance companies will pay 80% of covered services, but there are procedures that some insurance companies will not cover. You are responsible for these and any deductibles you may have.
- **WILL YANKE BIONICS, INC. WAIT FOR MY INSURANCE COMPANY TO PAY?** Yes, if you are prompt with payment of your portion of the bill. We will allow 30-45 days after filing for insurance settlement. The bill then becomes your responsibility. Although you are responsible for your entire bill, we want to help you receive every insurance benefit to which you are entitled.
- **WILL I RECEIVE A STATEMENT ON THE STATUS OF MY BILL?** Yes, you will receive a monthly statement for any open items. We ask that you give prompt attention to your bill, rather than waiting to see what insurance will pay.

BY SIGNING THIS AGREEMENT:

- I authorize the payment of benefits, both basic and major medical directly to the provider, Yanke Bionics, Inc., for services rendered. In the event that my insurance carrier should pay me directly, I agree I will endorse the check and remit directly to Yanke Bionics, Inc.
- I authorize the release of any information acquired in the course of my examination and/or treatment to my insurance carrier, attorney or others authorized by me. I acknowledge that I have read this statement and agree to abide by it.
- I certify that I have received a copy of Yanke Bionics, Inc. 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 Yanke Bionics, Inc. health care operations. The Notice of Privacy Practices also describes my rights and Yanke Bionics, Inc. duties with respect to my protected health information. Yanke Bionics, Inc. 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.

PATIENT SIGNATURE _____ DATE _____

IF PATIENT UNABLE TO SIGN, OR IF A MINOR, SIGNATURE OF PATIENT REPRESENTATIVE OR GUARANTOR _____

RELATIONSHIP TO PATIENT _____ DATE _____

OFFICE USE ONLY:

An attempt was made to obtain an acknowledgement of receipt of the Notice of Privacy Practices on _____

Medical reason patient was unable to sign: _____

Patient Name _____ Staff Member _____ Date _____