

Ontario Prosthetic Systems

Services Rendered By Prescription Only

Date _____

Phone _____

Patient's Name _____

Age _____ Date of Birth _____

Address _____

Sex _____ Height _____ Weight _____

City _____

Marital Status M S W D

Occupation _____

Referred By _____

EMPLOYMENT and BILLING INFORMATION

Name of Responsible Party(for billing Purposes) _____

Address(if different from patients) _____

Relationship to patient _____ Drivers License _____ Social Security # _____

Employer _____ Address _____

INSURANCE INFORMATON

Were you injured On the Job? Yes _____ No _____

If No, DO you have Private or Group Health Insurance? Yes _____ No _____

Name of Your Insurance Company _____

If you have an Insurance card, please present card at the front desk.

If Applicable, Please supply the name of your Industrial Insurance Carrier.

Name _____

Address _____

City _____ zip _____ Phone _____ - _____ - _____ Date of Injury _____

If suit be brought upon this note, or if by reason of default in payment, the same or any part there of be collected by an attorney, I (we) agree to pay a reasonable attorney's fee, or if this note is placed in the hands of collection agency I (we) agree to pay all collection charges as allowable by law, and also a reasonable attorney's fee.

If Default is made of any payment of principle, the legal holder of this note may declare the entire principal at once due and payable.

For value received each and every party who signs or endorses this note or becomes liable, either now or hereafter, for payment of this note severally waives presentment, demand, protest and notice of non-payment here of, binds himself here on as the principal and not as surety and agrees to remain bound here on not with standing any extension that may be made to any party liable on this note. At the option of the holder hereof, the venue of said suit may be laid in the county residence of the holder.

Signature: _____

(consent for treatment and for acceptance of financial responsibility)

(Parent or legal guardian must sign if the patient is a minor)

Assignment of Benefits

I hearby authorize Ontario Prosthetic Systems to furnish my insurance company all information which my insurance company may request concerning my illness or injury. I hereby assign to Ontario Prosthetic Systems all payments to which I am entitled for Orthopedic Appliances and/or prosthetic devices. I understand I am financially responsible to Ontario Prosthetic Systems for charges not covered by this assignment. A Photostat of this assignment is as valid as the original.

Date _____

Signed _____

(Signature of Policy Holder)