# PATIENT INTAKE FORM

**Date _____**

First Name _____ Middle Initial ____ Last Name _____

Address _____ Apt/Unit _____

City _____ State _____ Zip code _____

Gender ***Male*** *or* ***Female*** Height _____ Weight _____ DOB_____

**Contact Information**

Please share your preferred contact method. United Medical can either call, email, or text you regarding your current or future order. Your contact information will only ever be used to process your current order or future orders you might have. We will review all insurance coverage details, expected cost, and product information with you prior to placing an order. With that I mind, we cannot move forward if we cannot reach you, please provide your preferred and a back up method of communication below.

*Circle the preferred contact method of communication*

Home _____ Cell _____ Email Address_____

Does United Medical have your permission to communicate via message regarding urgent office updates, future orders, and/or appointment reminders?

**Emergency Contact Name** _____ Relation to Patient:_____

Contact Phone:_____ Contact Address: _____

May we share financial information with this contact? Yes☐ No☐
May we share medical information with this contact? Yes☐ No☐

**Referring Provider** _____

Referring Facility _____ Referring Facility Address _____

City _____ State _____ Zip Code _____

Phone _____ Fax _____

**Therapist Referrals Only** *(Circle Below)*

Where would you like to have your supplies shipped? Patient's Address or Therapist Facility

**Primary Insurance Information**

Primary Insurance Name _____ Member ID #_____

Policy Holder Name _____ Policy Holder Date of Birth _____ /_____/_____

Does the patient have secondary insurance? If yes, please list _____

If yes, please list the secondary ID # _____

# Benefits Assignment and Financial Responsibility

| Last name | First name | DOB |
|---|---|---|
| Address | | SSN |

**RELEASE OF INFORMATION:** I authorize **United Medical** to disclose and release to my insurance carrier(s), including Medicare, Medicaid, Medigap/Supplemental benefits providers, and private insurers, as applicable, any medical and treatment information needed for payment purposes for services rendered. I authorize the use of this form for the release of information needed to process claims to all my insurance carrier(s) and its authorized agents. I authorize my provider/practice to act as my agent in helping obtain payment from my insurance companies.

**ASSIGNMENT OF BENEFITS:** I assign all payments, rights and claims for reimbursement of claims, costs and expenses allowable under my insurance plan(s) directly to my provider or practice for services rendered. I understand I will receive a statement for any balance due by me and I agree to make full payment upon receipt of the statement after insurance has met its obligation.

**AGREEMENT OF RESPONSIBILITY:** I understand that **copayments are due at the time of the service** (coinsurance and deductibles may also be collected at the time of service). I understand I am financially responsible for charges not covered by my insurance company. I also agree to pay any outstanding balance as well as attorney fees and costs to **United Medical** if this matter is referred to collection.

**MEDICARE AUTHORIZATION:** If a Medicare beneficiary, I understand my signature requests payment to be made and authorize the release of medical information necessary to pay claims. If 'other health insurance' is indicated in item 9 of the HCFA-1500 Form, or elsewhere on approved claim forms, or electronically submitted claims, my signature authorizes the release of information to insurance companies or its authorized agents. In Medicare-assigned cases, the physician or supplier agrees to accept the charge of determination of the Medicare carrier as the full charge, and I agree I am responsible for deductible, coinsurance and non-covered services. Coinsurance and deductibles are based upon the charge determination of the Medicare carrier.

**The individual signing this form agrees and acknowledges as follows:**

(i) **Voluntary Authorization:** This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.

(ii) **Effective Time Period:** This authorization shall be in effect until the earlier of two (2) years after the death of the patient for whom this authorization is made.

**Patient Signature** _____ **Print Name** _____ **Date** _____

Information regarding health care provider or health care entity authorized to disclose and release information to:

UNITED MEDICAL INCORPORATED
4654 Haygood Road., Suite B, VA Beach VA 23455
(757) 363-7746 Office / (757) 363-8225 Fax

# CUSTOM MADE- MADE TO MEASURE
## GARMENTS AND PRODUCTS

***CUSTOM MADE AND MADE TO MEASURE GARMENTS AND PRODUCTS ARE NOT RETURNABLE!!!!!!***

**15 DAY FIT GUARANTEE ON ALL CUSTOM AND MADE TO MEASURE GARMENTS AND PRODUCTS. PATIENT IS RESPONSIBLE TO MAKE UNITED MEDICAL AWARE OF ANY ISSUES AND MAKE AN APPOINTMENT FOR EVALUATION AND MEASUREMENTS WITHIN 15 DAYS.**

If not originally measured at United Medical. We must have an evaluation by your Therapist with Repair/Alteration Request and **NEW** Measurements in order to request RA (Return Authorization) from Fabricator in this 15day time frame.

**INSURANCE AUTHORIZATION and/or COVERAGE IS NOT A GUARANTEE OF PAYMENT! Patient is Ultimately Responsible for Payment. Please initial by each line, sign and date at the bottom.**

**____(initial) I _____ agree that if my Insurance Company, _____ Denies and does not pay, I am responsible for the total COST of products ordered by United Medical. Once order is made, no returns or refunds are available. United Medical bills your insurance as a courtesy and I will not hold United Medical responsible.**

**____(initial) I understand that as the patient, I am responsible for all deductibles And copays.**

**____(initial) I understand the 15day fit guarantee and agree to it.**

**____(initial) I understand that If insurance denies or requests a refund from United Medical for any reason, I agree to pay the balance in full within 30 days to United Medical. If not paid with in 30 days, I agree to pay all costs United Medical Incurs (ie: court costs and attorney fees) to obtain payment.**

**____(initial) I understand that SEASONAL COLORS and PRINTS are custom & not returnable.**

**____(initial) I understand all terms and agree to order MY CUSTOM GARMENTS.**

_____ _____

**SIGNATURE** **DATE**

**4654 Haygood Rd., Suite B, Virginia Beach, VA 23455**

**(757) 363-7746 Office/ (757) 363-8225 Fax**

# AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

*This authorization may be used to permit a covered entity (as such term is defined by HIPAA and applicable Virginia law) to use or disclose an individual's protected health information. Individuals completing this form should read the form in its entirety before signing and complete all the sections that apply to their decisions relating to the use or disclosure of their protected health information.*

**Information regarding patient for whom authorization is made:**

Full Name: _____Date of Birth: _____

Address:_____ City:_____ State:_____ Zip Code:_____

Phone: (____)_____

**Information regarding health care provider or health care entity authorized to disclose and release information to:**

**UNITED MEDICAL INCORPORATED**
**4654 Haygood Road., Suite B, VA Beach VA 23455**
**(757) 363-7746 Office / (757) 363-8225 Fax**

**The individual signing this form agrees and acknowledges as follows:**

(i) **Voluntary Authorization:** This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.

(ii) **Effective Time Period:** This authorization shall be in effect until the earlier of two (2) years after the death of the patient for whom this authorization is made or the following specified date:

**Month: _____ Day: _____ Year: _____.**

(iii) **Right to Revoke:** I understand that I have the right to revoke this authorization at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

(iv) **Special Information:** This authorization may include disclosure of information relating to BELOW**:**

_____

_____

I specifically authorize release of such information to the entity indicated and listed ABOVE.

(v) **Signature Authorization:** I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.

**SIGNATURES:**

Patient/Legal Representative: _____ Date: _____

If Legal Representative, relationship to Patient: _____

Witness (optional): _____ Date: _____