PEDIATRIC ORTHOTIC SPECIALISTS
GC. MEYER, INC.

PATIENT INFORMATION:

NAME____DOB______________MALE / FEMALE

ADDRESS____________________________________CITY____________ST_____ZIP________

PHONE ( ) ________________________ALLERGIES__________________________

DIAGNOSIS____

PRIMARY CARE DR___________________________________PHONE ( )________________

REFERRING DR____________________________________PHONE( )________________

PHYSICAL THERAPIST__________________________FACILITY ____________________

PARENTS/GUARDIANS INFORMATION:

*Please **circle** best means of contact*

NAME____DOB________________

ADDRESS____________________________________CITY____________ST_____ZIP________

1.HOME ( )____________ **2**.CELL ( )______________ **3**.WORK ( )______________

4. EMAIL____________________________________Relationship to child________________

NAME____DOB ________________

ADDRESS____________________________________CITY____________ST_____ZIP________

1.HOME ( )____________**2**.CELL( )______________ **3**.WORK( )______________

4. EMAIL____________________________________Relationship to child________________

INSURANCE INFORMATION:

(Please provide cards to copy)

PRIMARY *(other than Medicaid/CSH)*
INSURANCE:____

POLICY NUMBER/**ID#** ____________________________GROUP #________________

SUBSCRIBER NAME____DOB____________

PLACE OF EMPLOYMENT____

SECONDARY *(other than Medicaid/CSH)*
INSURANCE:____

POLICY NUMBER /**ID#**____________________________GROUP #________________

SUBSCRIBER NAME____DOB____________

PLACE OF EMPLOYMENT____

MEDICAID/MCD HEALTH PLAN/CSH ID#________________PLAN__________

Warranty/Refunds- custom items have limited warranty for a period of 90 days under normal conditions of wear. Adjustments/repairs due to normal wear after 90 days may be charged. Return of custom made items will not be accepted unless there is a deficiency with workmanship.

Financial Responsibility - GC Meyer, Inc recommends the responsible party contact their insurance company to determine benefits/covered services.

I understand that I am financially responsible to GC Meyer, Inc/Pediatric Orthotic Specialists for all services/supplies not covered by liability and/or by my medical coverage. I acknowledge that I will receive verbal and written instructions on the items received.

Medical records authorization & insurance assignment -the undersigned authorizes GC Meyer, Inc to release any medical information(unless specifically excluded by patient or guarantor) for continuing care needs or payment of account by my insurance company or employer. I authorize my insurance carrier pay directly to GC Meyer, Inc liability and/or medical coverage insurance proceeds for all services and/or supplies rendered by GC Meyer, Inc. Authorization is good for one (1) year from today's date unless revoked by me, but not retractive to release.

Signature of parent/guardian______________________________Date__________