GoFeet Orthotics Patient Information Form

Patient's Name: _____ Birthdate: _____
(Last) (First) (MI)

Street Address: _____

City, State, Zip:_____

Gender: Male_____Female_____ Primary language in home?_____

Parent/Guardian Name:_____

Relationship to patient:_____

Phone number:_____

Email address:_____

Preferred method of communication (circle one): Call Text Email

_ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Secondary Contact:_____

Relationship to patient:_____

Phone number:_____

Is your child currently seeing a Physical Therapist? Yes or No

If yes, please provide name of therapy group/therapist name and contact information:

_____

Has your child received a similar service within the past 12 months? **Yes or No**

If so, please provide additional information: _____

Primary care Physician/Pediatrician: _____

Name of Practice:_____

Phone number:_____

Primary Insurance Company: _____

Policy#: _____

Guarantor's name & DOB (if private insurance only): _____

Secondary Insurance Company: _____

*Policy#*_____

Guarantor's name : _____ DOB: _____

Does your child have Babynet services? Yes or No

If yes, please provide Early Interventionist name and contact information below:

_____

I attest that the information provided above is accurate:

Signature_____**Date**_____

Print_____**Relationship**_____

Consent to evaluate and treat with GoFeet Orthotics

1. I authorize the staff of GoFeet Orthotics to evaluate and treat as ordered by my physician.
2. I authorize any holder of medical information about me to release information to GoFeet Orthotics and its agents, or to my insurance company any information needed to determine these benefits or the benefits payable for related services.
3. I request that payment of authorized Medicare, Medicaid, or private insurance benefits be made to GoFeet Orthotics for any covered services furnished by GoFeet Orthotics. I agree to pay GoFeet Orthotics the deductible and/or coinsurance on my claim.
4. I have been provided a copy of my privacy rights as required by the HIPPA Privacy Regulations (GF Privacy Policy).
5. I understand that I am financially responsible for charges not covered by insurance, and I have been provided a copy of, or offered a copy, of GoFeet Orthotics Financial Policy.
6. I will contact the office at 864-252-4377 with as much notice as possible (preferably 24 hours before) when I need to cancel or change my appointment.
7. I authorize GoFeet Orthotics to communicate treatment information by normal email and/or text.

Patient Name_____ Date_____

Signature of Patient/Representative _____

Representative Printed Name_____

Relationship to patient_____

Photo Release

❑ I grant GoFeet Orthotics permission to take photographs of my child

** By granting permission to take photos of my child, I am agreeing that GoFeet Orthotics may use such photographs for any lawful purposes. These may include illustration, advertising and website/social media content.

❑ I do **NOT** grant GoFeet Orthotics the right to take photographs of my child

I have read and understand the above:

Patient name _____ Date _____

Signature (parent/guardian) _____

Print (parent/guardian) _____