Center for Custom Prosthetics

David Trainer
Maxillofacial Prosthetist

Jorge Franco Canales
Maxillofacial Prosthetist/Ocularist

Patient Information Please fill out this form in it's Entirety

Name: _____Todays Date:____/.____/.___

D.O.B:_____/_____/_____ SS #:_____-_____-_____ Marital Status: S / M / D / W

Primary Address: _____

City: _____ State: _____ Zip: _____

Secondary Address: _____
City: _____ State: _____ Zip: _____

CELL Phone:( )_____-_____ EmailAddress:_____

Home Phone:( )_____-_____. Work Phone:( )_____-_____

Insurance Information. Medical conditions / allergies: _____

Primary Insurance: _____ID #: _____

Secondary Insurance: _____ID#: _____

Subscriber Name: _____ D.O.B:_____/_____/_____

Spouse/ Parent Name: _____ D.O.B.:_____/_____/_____

Primary Care Physician/Reffering Physician. How did you hear of us?_____

Doctors Name_____

Address:_____City:_____
State:_____ Zip:_____ Referred by:_____

Phone:( ) _____- _____ Fax:( )_____-_____

Prosthetic History

Type of Prosthesis: Eye R / L Orbital R / L Ear R / L Nose Other: _____

Who made your prosthesis:_____Adhesive or Magnets:_____

Phone:( )_____-_____How old is your current prosthesis: ___ yr (s) / mo. What year was your first Prosthetic?_____ If Surgery, Date of surgery:_____

Ophthalmologist : _____ Ph: ( ) _____

How often do you have your prosthesis cleaned and polished:_____

Center for Custom Prosthetics

David Trainer
Maxillofacial Prosthetist
Partner/Owner

Jorge Franco Canales
Maxillofacial Prosthetist/Ocularist

INSURANCE POLICY/PROCEDURES AND CONSENT FOR TREATMENT

Raymond E Peters, Inc. Center for Custom Prosthetics, policy is to collect 50% of our fee on your initial appointment, and the remainder upon the delivery of your custom prosthesis. We offer Visa, Master Card, Discover, American Express and 3rd Party Financing (Care Credit). Raymond E. Peters Inc., (DBA Center for Custom Prosthetics) is a provider with Blue Cross and Blue Shield, which means they will accept claims of our patients and give "reasonable and customary" allowances. Raymond E. Peters, Inc., (DBA Center for Custom Prosthetics), is NOT a participating provider with Medicare, which means they cannot regulate our fees. Medicare as well as independent insurance companies, consider Raymond E. Peters, Inc., (DBA Center for Custom Prosthetics), a Durable Medical Equipment /Prosthetic (DME) provider, which is under a different guidelines than the Medical Association (AMA) with participating physicians. **Claims Submission:** We will submit your claims as a courtesy to you, and assist you in anyway we reasonably can to help get your claims paid. Please be a wear that the balance of your claim is your responsibility wether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company we are not party to that contract. Medicare allowances (reimbursements) for our custom prosthetics services are 80% of their "**Allowed Amount**". Your secondary insurance, if you have one, reimburses the remaining 20% of Medicare's allowed amount. If you don't have a secondary insurance, patient is responsible for the 20% Reimbursements amount depends on which Medicare jurisdiction you are residing in permanently. **Note** that if your deductible has not been satisfied, they will deduct this from the reimbursed amount and the patient is responsible for the unpaid deductible amount. **We maintain a NO REFUND POLICY, once fabrication has proceeded. With the under signed signature I consent to begin the fabrication of my prosthesis. I willingly consent to have David Trainer Maxillofacial Prosthetist, and Jorge Franco Canales Ocularist , examine, evaluate and fabricate a custom prosthesis(s), and accept total responsibility for payment of these services/ fees. I further agree to forward all payment to Raymond E Peters, Inc. that I receive from my insurance carrier for services rendered.**
Initial the following highlighted areas:

_____ I the undersigned patient/responsible party consent to the medical procedures, treatments and examination to be rendered for the request of an artificial prosthesis and/ or related services as of this date.
_____ I undersigned patient/responsible party am responsible for supplying the necessary insurance and physician information to obtain a Written Physician's Order in order to proceed with the above mentioned services.
_____ I undersigned patient/responsible party, in order to assist in the dissemination of medical and scientific knowledge, or in the improvement of medical diagnosis and treatment, authorize the Raymond E. Peters Inc. (DBA) Center for Custom Prosthetics to release, publish, display, or otherwise photographs, model and/or videotapes which are obtained in connection with my treatment. It is undersigned and agreed that names will not be used or in anyway disclosed in connection therewith.
_____I the undersigned patient/responsible party acknowledge reading a copy of Notice of Privacy Practices and understand the terms and conditions written therein
_____ Please note that PI/RMA's prosthetic services are billed directly to your primary insurance carrier, and then to your supplemental insurance carrier. Depending on your insurance coverage you may be required to pay your deductible and your co-insurance when you start your prosthesis on the first day fabrication begins. You will be billed for any remaining balance after the insurance payment has been removed if any
_____ I undersigned patient/responsible party request that the payment of authorized benefits be made on my behalf for any services furnished by Raymond E. Peters Inc.(DBA) Center for Custom Prosthetics. I authorize any holder of medical or other information about me (including but not limited to chart notes, clinical, photographs and/or models) which are obtained in contain with my treatment be released to the appropriate insurance agency and its agents as needed to determine these benefits or befits released services. I permit a copy of this authorization to be used in place of the original.
_____ I undersigned patient/responsible party authorizes Raymond E. Peters Inc.(DBA) Center for Custom Prosthetics to disclose financial and medical information to those who are or may be responsible for payment of all or a portion of the charges including medical records to my employer For Workmans compensation and/or third party payers, to other health care accreditations, admits, certification, appeal councils and peer or utilization reviews.
_____ I undersigned patient/responsible party authorizes to have Raymond E Peters Inc.(DBA) Center for Custom Prosthetics to examine, evaluate and fabricate a custom prosthesis and accept total responsibility for payment of these services/fees. I further agree to forward any and all payments to Raymond E. Peters Inc.(DBA) Center for Custom Prosthetics that i receive from my insurance carrier for the services rendered. I do understand that I am responsible for any balances due on my account after insurance payment has been received.
_____ 48 business hours notice is required for cancelled or rescheduled appointments. A cancelled/missed appointment fee is $100, as we will be unable to utilize the time reserved for other patients.
_____ I the undersigned patient/responsible party acknowledge, I must contact staff to update any changes in insurance information, and/or address changes. To prevent delay my medically necessary, replacement prosthesis.
The undersigned patient/responsible party acknowledge receipt of a copy of this form, and agrees to the terms set forth in this form. We maintain a NO REFUND POLICY, once fabrication of your prosthesis has preceded.

SIGNATURE_____DATE_____