NuTech Institute LLC

Patient Information Form

Please be sure to bring the following items to your first appointment:

- Photo ID
- Insurance Card(s)
- Prescription or Referral

PATIENT INFORMATION

Last Name:	First Name:	Middle Initial:	Preferred Name:

Date of Birth:	Gender: (check or fill) Male ☐ Female ☐	SSN:	E-mail Address:

Mailing Address	City	ST	Zip Code	Primary Language:

Marital Status	Home Phone:	Ok to Leave Message: Yes ☐ No ☐	Cell Phone:	Ok to Leave Message: Yes ☐ No ☐

How Did You Hear About Us? ☐ Other:___________________ ☐Doctor/Hospital ☐Patient ☐ Friend/Family ☐Internet	How may we contact you? Phone: Yes ☐ No ☐ Email: Yes ☐ No ☐

Referring Doctor:	Primary Care Doctor:

RESPONSIBLE PARTY INFORMATION (PARENT / GUARDIAN)

Guarantor Name:	Address:	Phone Number:	Ok to Leave Message: Yes ☐ No ☐

E-Mail Address:	Date of Birth:	Relationship to Patient:

EMERGENCY CONTACT/ WHO WE CAN COMMUNICATE WITH REGARDING APPOINTMENTS AND MEDICAL INFO.

Name (First, Last):	Relationship to patient:	Phone:	OK to Leave a Message:
			Yes ☐ No ☐
			Yes ☐ No ☐

INSURANCE INFORMATION ***PROVIDE YOUR INSURANCE CARD***

Please Check Box If SELF Pay ☐

Worker's Comp Case: **Yes** ☐ **No** ☐

1. Primary Insurance Company	ID#:

Subscriber Name:	Relationship to Patient:	Phone#:	DOB:	SSN:

2. Secondary Insurance Company		ID#:		
Subscriber Name:	Relationship to Patient:	Phone#:	DOB:	SSN:
Workers' Compensation Claim				
Workers' Compensation Claim?	Yes ☐ No ☐	Date of Injury:		
Insurance Carrier:		Claim Number:		
Claim Adjuster Name:		Employer at DOI:		
Claim Adjuster Phone:		Employer's Phone:		

NuTech Institute LLC Financial Responsibility and Returns Policy

NuTech Institute LLC can in no way guarantee your insurance coverage. Benefits are determined by your insurance plan at the time that your claim is processed. All benefit calculations are only an estimate, based on information obtained from your insurance company. The actual Total Patient's Responsibility may be different than what was previously estimated by NuTech Institute.

To prevent any misunderstanding about medical insurance, we wish to point out the following details:

- Payment for all medical services furnished are your responsibility,
- For patients with confirmed insurance, your deductibles, co-insurance payments, and/or other patient responsibility amounts are due at the time of THE DELIVERY OF YOUR DEVICE,
- For patients without confirmed insurance, who are being provided with a custom-made device, fifty percent (50 %) of the total balance is due at the casting appointment and the remaining balance is due at THE DELIVERY OF YOUR DEVICE,
- NuTech Institute will bill your insurance company as an additional service for you, but NuTech Institute is not responsible for non-payment from the insurance company,
- If, due to unforeseen circumstances, additional procedures and/or treatments are necessary beyond what has been previously approved, you must make arrangements for payment with the Administrative Team, and
- You are expected to keep your account current while waiting for your insurance company payment.

In consideration of NuTech Institute's efforts to provide our patients with services and/or products, the patient or guarantor agrees that each of them is responsible for payment. Payments may be made by check, money order, Visa or MasterCard. Returned checks and balances older than 30 days may be subject to additional collection fees and interest charges of up to 5%.

Given the nature of the solutions being provided, NO REFUNDS will be given for the following items:

- Custom-Made items such as prostheses or orthoses,
- Prosthetic Supplies such as liners, sleeves or socks,
- Non-stock items,
- Special Order products, or
- All other items will be reviewed on a case-by-case basis.

I have read and agree with the Payment and Policy agreement. I also certify the information provided by me is true, accurate and complete to the best of my knowledge.

____ _______________________
Printed Name of Patient / Parent of Minor / Guarantor   Relationship to Patient

____ _______________________
Signature of Patient / Parent of Minor / Guarantor   Date