SIERRA
Orthopedic Laboratory, Inc.

REGISTRATION FORM

Today's date:	**Patient ID #:**	**Primary Care Doctor:**

PATIENT INFORMATION

Patient's Full Name:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	**Marital status (circle one)** Single/Mar/Div/ Sep/ Wid

D.O.B: / /	**Sex:** ❑ M ❑ F	**Social Security Number:**

Home Phone Number: ( )	**Cell Number:** ( )	**May We Leave a Detailed Message:** ❑ Yes ❑ No

Street Address:	**City:**	**State:**	**ZIP Code:**

Emergency Contact:	**Relationship to Patient:**	**Phone Number:**

May We Contact Above Named If Unable to Reach You:	❑ **Yes** **or** ❑ **No**	**Office Use Only (check one)** **OR** ❑ **PX** ❑

How Would You Like to Be Reminded of Upcoming Appointments?	❑ **Call** **or** ❑ **Text**

INSURANCE INFORMATION

******(Please Give Your Insurance Card to The Receptionist) ******

Person responsible for bill:	Birth Date: / /	Address (if different):	Home Phone Number: ( )

Primary Insurance:				
Subscriber's Name:	Subscriber S.S.N:	Birth Date: / /	Policy Number:	Group Number:

Patient's Relation to Subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other:

Name of Secondary Ins *(if applicable):*	Subscriber's Name:	Policy Number:	Group Number:

Patient's Relation to Subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other:

IS THIS A WORK-RELATED INJURY:

❑ **Yes** ***(if yes complete below)*** **or** ❑ **No** ***(if no skip to signature)***

Employer at Time of Injury:	
Primary Treating Physician:	Claim Number:
Date of Injury:	Accepted Body Part:
Adjuster Name:	Adjuster Number:

SIGNATURE

The Above Information Is True to The Best of My Knowledge.

Patient/Guardian signature: _____ **Date:** _____

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____ **Patient ID #:** _____

Date of Birth: ____/____/____ SS#: _____

I Request and Authorize: _____
(List All Providers Patient See's for Current Medical Condition)

To Release Healthcare Information of The Patient Named Above To:

********** **SIERRA ORTHOPEDIC LABORATORY, INC.**********

This Authorization Applies To: *(please **check one** of the boxes below):*

☐ Healthcare Info Relating to The Following Treatment, Condition, Or Dates:

_____

☐ All Healthcare Information

Patient/Guardian Signature: _____ **Date:** _____

*This Authorization Is in Effect from Today's Date and **Expires Seven (7) Years** from Today's Date. Unless Terminated in Writing Prior To By the Patient and/or Guardian. Copies of This Authorization Shall Be Deemed as Valid as The Original.*

4847 Old Redwood Hwy, Santa Rosa CA 95403
(707) 528-9808 ◆ (800) 315-9808 ◆ Fax: (707) 528-9818

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SIGNATURE PAGE

PATIENTS NAME: _____ **PATIENT ID #:** _____

INSURANCE ASSIGNMENT AGREEMENT

I authorize my insurance benefits be paid directly to Sierra Orthopedic Lab (further referred to as **SOL**). I understand that I am financially responsible for any out of pocket expenses I may have such as: co-pay, co-Ins, and deductible. I also authorize SOL or the insurance company to release any health care information that is required to process my claims.

Initial_____ I have read, understand, and agree to the terms and conditions of ***SOL INSUR ASGMNT AGREEMENT***

WARRANTY POLICY

*Orthopedic Devices fit or provided by SOL are under warranty for 90 days from the date of delivery against any breakage due to defects in materials or workmanship.
*Adjustments to the device to provide comfort within reasonable expectations are under 90-day warranty.
*Repairs, adjustments, or replacement of the orthopedic device which are required due to weight gain or loss, or change in size of extremity or due to inappropriate utilization are not covered under the warranty.
*There will be additional charges if adjustments or replacement of the orthopedic device are necessary due to a change in the prescription or change in the requirements of the orthopedic device.
*The warranty is voided if the orthopedic device has been modified or adjusted by anyone other than SOL.

Initial_____ I have read and understand the terms and conditions of the ***SOL WARRANTY POLICY***

PATIENT RIGHTS

*Be seen in our office within a reasonable amount of time once you are referred to our office.
*Be seen in a timely manner once you are in our office for an appointment.
*Be seen by a qualified practitioner.
*Have warranty protection on the device you receive from SOL.
*Be seen in a safe, clean and accessible facility.
*View your patient records.
*Have your confidentiality maintained regarding you records.
*Your signed "Release of Information" form is required for us to share any part of your record with outside sources.
*Timely and efficient resolution of conflicts.
*Know the cost of your orthotic appliance and the payment/billing policy.
*Be treated respectfully by all staff members.
*Privacy when being fitted with your device.

Initial_____ I have read and understand the terms and conditions of the ***SOL PATIENT RIGHTS POLICY***

PRIVACY POLICY & MEDICAL SUPPLIERS STANDARDS

*****SEE ATTATCHED PACKET*****

Initial_____ I have read and understand the terms and conditions of the ***SOL PP & DMEPOS SUPP STANDARDS***

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