Connecticut Brace and Limb
512 Saybrook Road - Lower Level
Middletown, CT 06457
860-740-2154
Fax: 860-421-4178

Today's Date:_____

Patient Name_____ DOB: _____

Address:_____

City: _____ State: _____ Zip: _____

Pt. Phone# _____ SSN: _____

Email_____ Occupation _____

Gender _____ Marital Status: _____ Ht: _____ Wt: _____

Referring Physician_____Phone_____

Family Physician_____ Phone_____

Was this a work related injury? **YES** or **NO** If yes, complete next section:

Employer at the time of injury: _____

Employer phone: _____Date of injury: _____Claim #: _____

Primary Insurance _____	Secondary Insurance _____
Policy # _____	Policy # _____
Ins. Phone: _____	Ins. Phone: _____

I request that payment of authorized Medicare or other insurance benefits be made either by me or on my behalf, to Connecticut Brace and Limb for goods and services provided by Connecticut Brace and Limb. I authorize any holder of medical information about me to release to the Centers for Medicare, Medicaid or other insurance services and its agents any information needed to determine these benefits or the benefits payable related services to release any information necessary to process this claim. I also understand that I am financially responsible for payment of services provided. I also acknowledge that I have received a copy of the HIPPA Privacy Practices and a copy of the Patient's Rights Policy. The products and/or services provided to you by CTBL are subject to the supplier standards contained in the Federal regulation shown at 42 Code of Federal regulation Section 424.57 These standards concern business professional and operational matters (e.g. honoring warranties and hours of operation.) The full test of these standards can be obtained at http://ecfr.gpo.gov. Upon request we will furnish you a written copy of these standards.

Signature_____Date_____