LUMEN ORTHOTICS & PROSTHETICS

"Lighting the journey with family focused care"

PATIENT INFORMATION

Patient's Name	**DOB**	**Gender**
Parent/Guardian	**Cell Phone**	**Home Phone (if applicable)**
Address / City / State / Zip code		
Parent/Guardian Email Address:		
Emergency Contact Name/Phone (other than listed above) / Phone #		

Primary Care Physician	**Physician's Phone Number**
Referring Physician (if applicable)	**Physician's Phone Number**

PRIMARY INSURANCE

Name of Insured	**Relationship to Patient**	**Insured DOB**	**Insured SSN**
Insured Address (if different than above)	**Insurance Carrier**	**Employer (if applicable)**	
Identification/Policy Number	**Group Number**	***Please provide a copy of front and back of insurance card**	

SECONDARY INSURANCE (if applicable)

Name of Insured	**Relationship to Patient**	**Insured DOB**	**Insured SSN**
Insured Address (if different from above)	**Insurance Carrier**	**Employer (if applicable)**	
Identification/Policy Number	**Group Number**	***Please provide a copy of front and back of insurance card**	

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PERMISSION TO EVALUATE AND PROVIDE TREATMENT

I authorize Lumen Orthotics & Prosthetics, LLC to evaluate and provide the recommended services to my child. Lumen Orthotics & Prosthetics, LLC has promised no specific outcomes as to the services provided at this facility.

Patient Name:_____ DOB:_____

Parent/Legal Guardian:_____ Relationship to Patient:_____

Date:_____

FINANCIAL RESPONSIBILITY

I authorize Lumen Orthotics & Prosthetics, LLC to bill my child's insurance for services rendered and receive direct payment from primary as well as secondary insurances. Furthermore, I understand that I am financially responsible for any fees not paid or covered by my child's insurance providers. I also acknowledge that I am responsible for co-pays, co-insurance, deductibles and out of pocket charges as indicated by my child's insurance company(s).

I understand and agree that regardless of insurance status, I am ultimately responsible for the balance of my account for any professional services rendered by Lumen Orthotics & Prosthetics, LLC.

Patient Name:_____ DOB:_____

Parent/Legal Guardian:_____ Relationship to Patient:_____

Date:_____

CONSENT TO UNSECURE TEXT MESSAGING

By providing your signature, you consent to receive text messages from Lumen Orthotics & Prosthetics, LLC related to appointments, account updates, or services. These messages may not be encrypted or secure, which means there is a risk that unauthorized third parties could intercept or access the information.
By signing, you acknowledge and accept this risk and authorize us to communicate with you via unsecure text messaging. You can opt out at any time.

If you have questions or concerns, please contact us at (260) 450-4999.

Patient Name:_____ DOB:_____

Parent/Legal Guardian:_____ Relationship to Patient:_____

Date:_____

LUMEN ORTHOTICS AND PROSTHETICS, LLC
HIPAA AUTHORIZATION

Patient's Name:_____ Date of Birth:_____

Address:_____

I hereby authorize use or disclosure of protected health information about my child as described below:

Lumen Orthotics & Prosthetics, LLC and its employees are authorized to use or disclose health information that is pertinent or required for therapy purposes. Lumen Orthotics & Prosthetics LLC may disclose health information considered pertinent to services to a patient's insurance company, physician, teacher, social worker, and other involved professionals.

This authorization may be revoked at any time by notifying Lumen Orthotics & Prosthetics, LLC in writing. Any action already taken in reliance on this authorization cannot be reversed, and the revocation will not affect those actions. This authorization automatically expires when the patient is discharged by Lumen Orthotics & Prosthetics LLC unless the agency receives a written notification from the parent/legal guardian prior to discharge.

In addition, I give permission for the individuals listed below to transport/participate in my child's appointments. These individuals also have my permission to sign any required documentation related to my child's treatment such as treatment notes, attendance verification, etc.

Name of Individual	Relationship to Child	Contact Number

Parent/Legal Guardian Printed Name: _____

Parent/Legal Guardian Signature:_____

Date of Signature:_____

Lumen Orthotics and Prosthetics, LLC

Notice of Privacy Practice

Lumen Orthotics & Prosthetics is committed to maintaining your privacy. The purpose of this notice is to define how we will use and disclose your medical information. This form is a condensed version of the full legally required document, "Notice of Privacy Practices". A copy of the entire document is available at your request.

Any information we obtain about you, either through you or others, will be used to provide you with *treatment,* to arrange *payment* for our services, or for additional business activities identified in the law as *health care operations.* We are required to notify you in the event of a breach of your unsecured protected health information.

There are certain situations where we are required to disclose your personal medical information. These include:

- When required to do so by federal, state, or local law
- Any known threat to your health and safety or to that of others
- As required by law, a health oversight agency for authorized activities when properly ordered to do so by a court
- Public health risk reporting as required by federal and/or state law
- Personal medical information will be released as requested by a law enforcement official, if permitted by law
- As requested by authorized federal officials in order to provide protection to the President, conduct special investigations or for the protection of other authorized persons
- Additional special circumstances identified in the "Notice of Privacy Practices"

Your Rights Regarding Your Health Information

- You have the right to a copy of electronic protected health information in the format it is maintained.
- You have the right to inspect your personal file and copy medical information as needed. There are some exceptions that apply and you may be charged a fee for copies. Please contact our Privacy Officer for information.
- You have the right to request that certain individuals involved in your care are not given access to your personal medical information, i.e., family and friends. You must submit your request to the Privacy Officer who has the authority to approve or deny the request. Should we agree with your request, there may be events 'that will require the sharing of information such as circumstances required by law, emergencies or when the information is necessary in order for treatment.
- You have the right to request an amendment to your medical information if you feel that the information is incorrect or incomplete. Requests, complete with reasons, must be submitted to the Privacy Officer. The Privacy Officer reserves the right to approve or deny the request.
- With some exceptions, you have a right to an accounting of all disclosures of your medical information released by Possibilities Northeast. You may request that disclosure of personal medical information be restricted and/or limited. Possibilities Northeast has the right to deny your request.
- You have the right to receive communications regarding medical information in a specific manner or locations i.e. home or work, paper copies, e-mail, telephone, etc. We require that your request be in writing.
- At all times, you have the right to receive a paper copy of the legal notice entitled "Notice of Privacy Practices". This notice is posted in our main office and a copy is available by contacting the Privacy officer for Lumen O&P, Chris George 260-450-4999.
- You have the right to file a complaint if you believe your privacy rights have been violated. You can file your complaint with our Privacy Officer or the Secretary of the Department of Health and Human Services.

Any questions regarding this notice should be directed to our Privacy Officer: Chris George, Owner
Lumen Orthotics & Prosthetics, LLC
5310 Merchandise Drive
Fort Wayne, Indiana 46804
260-450-4999

05/22/2025

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

Patient's Name:_____DOB:_____

My signature below indicates that I have received a copy of Lumen O&P "Notice of Privacy Practices" per HIPAA guidelines.

Parent/Legal Guardian: _____ Date:_____
Printed Name

Parent/Legal Guardian: _____ Date:_____
Signature

Lumen Orthotics and Prosthetics
5310 Merchandise Dr.
Fort Wayne, IN 46825