American Limb & Orthopedic Company of Valparaiso

American Limb & Orthopedic Co. of Valparaiso

201 E Morthland Drive Suite 2
Valparaiso, Indiana 46383
Phone: (219) 531-7479 Fax: (219) 531-0465
www.americanlimbvalparaiso.com

PATIENT INFORMATION

Date: _____ **Home Phone:** _____ **Cell Phone:** _____
NAME _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____
BIRTHDATE _____ SOCIAL SECURITY # _____
EMAIL _____
EMPLOYER _____ PHONE# _____
EMERGENCY CONTACT NAME _____
PHONE# _____
REFERRING PHYSICIAN NAME _____
PHONE# _____
FAMILY PHYSICIAN _____
ARE YOU DIABETIC? Yes _____ No _____
HAVE YOU EVER BEEN FIT WITH AN ORTHOTIC/BRACE OR
PROSTHETIC? YES _____ NO _____

IF PATIENT IS A CHILD OR DEPENDENT, PLEASE COMPLETE THIS SECTION

NAME OF RESPONSIBLE PARTY _____
RELATIONSHIP _____ BIRTHDATE _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____
TELEPHONE # _____ SOCIAL SECURITY # _____
EMPLOYER _____ TELEPHONE# _____

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RELEASE/CONSENT FORMS

PLEASE READ CAREFULLY AND ***INITIAL EACH ONE*** BELOW:

_____ 1. The patient requests that payment of authorized insurance benefits be made, on the patient's behalf, to the American Limb & Orthopedic Company of Valparaiso for the orthotic or prosthetic services rendered. The patient understands that their signature (below) authorizes payment by the insurance carrier to be made directly to the American Limb & Orthopedic Company of Valparaiso.

_____ 2. The patient authorizes any holder of medical information, regarding the patient that is needed for clinical purposes or for the determination of benefits, or benefits payable, for related services are released to the American Limb & Orthopedic Company of Valparaiso. The patient understands that their signature (below) authorizes the release of medical information.

_____ 3. American Limb & Orthopedic Company of Valparaiso is not a financial lending institution; therefore, payment arrangements cannot be made with us. We accept major credit cards, cash, check, money orders and Care Credit. Full payment is due on the date of service or time of delivery. For custom items, we require a down payment of half the amount that is due before work will begin on any item. **When making payment by any type of credit card, a 4.2% processing fee is added to all transactions and is non-refundable. Returned checks will be subject to a $50 fee.*

_____ 4. The patient agrees to assume financial responsibility for any claim not covered by the insurance policy or portion of claim thereof such as a non covered item, deductible, or co-pay due to the American Limb & Orthopedic Company of Valparaiso for services rendered. If the insurance company denies coverage for a product, the patient will assume financial responsibility for this payment. The patient acknowledges the responsibility for any payment not received from the insurance carrier within sixty (60) days from the date of service. Returned checks and balances older than 60 days may be subject to additional collection charges. (I) as the patient or (We) as the guarantor of the mentioned person herby agree to pay all incurred charges mentioned above. I further agree upon default to pay 1 ½ % per month (18% per annum) on any unpaid balances along with all costs of collection including attorney fees. I further agree that any dispute with regard to payment of this debt shall be subject to the laws of Indiana and by my signature submitting myself to the jurisdiction of the courts of Indiana.

_____ 5. It is the responsibility of the patient to notify American Limb & Orthopedic Company of Valparaiso of any changes in insurance coverage, employment, functional status, or personal information such as address and telephone contact information.

_____ 6. When scheduling an appointment with American Limb & Orthopedic Company of Valparaiso, we reserve the time slot for you to be seen. Should you need to cancel or reschedule this appointment, please call our office a minimum of 24 hours in advance at 219-531-7479 to avoid a $35 fee.

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_____ 7. I certify that I am aware a full copy of American Limb & Orthopedic Co. of Valparaiso's Notice of the Privacy Practices is available to me at any time at www.americanlimbvalparaiso.com. American Limb & Orthopedic Co. of Valparaiso reserves the right to change the privacy practices at any time.

_____ 8. Please be advised, per Medicare, Medicaid, and Insurance regulations, we are asking that you inform us if you have received any type of orthotic device within the last 5 years. Some insurance regulations only cover a new device every 5 years.

_____ **Yes**, I have received an orthotic (brace) device within 5 years.

- How old if your current device? _____
- Which side of the body are you wearing your current device? _____
- Is your device being replaced due to change in your physical condition?
  - _____Yes
  - _____No
- Does your current device need to be replaced because it is broken?
  - _____Yes
  - _____No
- Is your prescription/order for a different type OR different side of your body?
  - _____Yes
  - _____No

_____ **No**, I have not received an orthotic (brace) device within 5 years.

_____ 9. I hereby grant American Limb & Orthopedic Co. of Valparaiso to use photos or videos of me taken at agreed locations in publications, news releases, online, and in other communications related to the mission of American Limb & Orthopedic Co. of Valparaiso.

- _____Yes, my photos can be used.
- _____No, I would not like my photos used.

_____ 10. All insurance companies are different and coverage of medical benefits can change without notice. We render our services on the basis that insurance companies may or may not pay for a device. You are personally responsible for knowing and understanding your own insurance policy, coverage, and benefits. All insurance companies state that verification of coverage is not a guarantee of coverage or payment. Actual benefits are determined by your insurance company after a claim is filed. If you have any questions about your insurance, we are happy to assist, however, specific coverage questions should be directed to your insurance company.

(Print) Patient's Name: _____ **Date:** _____

Signature of Patient, Parent, Guardian or Guarantor

X_____

INSURANCE DMEPOS SUPPLIER STANDARDS

Note: This is an abbreviated version of the supplier standards every Medicare DMEPOS supplier must meet in order to obtain and retain their billing privileges. These standards, in their entirety, are listed in 42 C.F.R. 424.57(c).

1. A supplier must be in compliance with all applicable Federal and State licensure and regulatory requirements.
2. A supplier must provide complete and accurate information on the DMEPOS supplier application. Any changes to this information must be reported to the National Supplier Clearinghouse within 30 days.
3. A supplier must have an authorized individual (whose signature is binding) sign the enrollment application for billing privileges.
4. A supplier must fill orders from its own inventory, or contract with other companies for the purchase of items necessary to fill orders. A supplier may not contract with any entity that is currently excluded from the Medicare program, any State health care programs, or any other Federal procurement or non-procurement programs.
5. A supplier must advise beneficiaries that they may rent or purchase inexpensive or routinely purchased durable medical equipment, and of the purchase option for capped rental equipment.
6. A supplier must notify beneficiaries of warranty coverage and honor all warranties under applicable State law, and repair or replace free of charge Medicare covered items that are under warranty.
7. A supplier must maintain a physical facility on an appropriate site and must maintain a visible sign with posted hours of operation. The location must be accessible to the public and staffed during posted hours of business. The location must be at least 200 square feet and contain space for storing records.
8. A supplier must permit CMS or its agents to conduct on-site inspections to ascertain the supplier's compliance with these standards.
9. A supplier must maintain a primary business telephone listed under the name of the business in a local directory or a toll free number available through directory assistance. The exclusive use of a beeper, answering machine, answering service or cell phone during posted business hours is prohibited.
10. A supplier must have comprehensive liability insurance in the amount of at least $300,000 that covers both the supplier's place of business and all customers and employees of the supplier. If the supplier manufactures its own items, this insurance must also cover product liability and completed operations.
11. A supplier is prohibited from direct solicitation to Medicare beneficiaries. For complete details on this prohibition see 42 CFR § 424.57 (c) (11).
12. A supplier is responsible for delivery of and must instruct beneficiaries on the use of Medicare covered items, and maintain proof of delivery and beneficiary instruction.
13. A supplier must answer questions and respond to complaints of beneficiaries, and maintain documentation of such contacts.
14. A supplier must maintain and replace at no charge or repair cost either directly, or through a service contract with another company, any Medicare-covered items it has rented to beneficiaries.
15. A supplier must accept returns of substandard (less than full quality for the particular item) or unsuitable items (inappropriate for the beneficiary at the time it was fitted and rented or sold) from beneficiaries.
16. A supplier must disclose these standards to each beneficiary it supplies a Medicare-covered item.
17. A supplier must disclose any person having ownership, financial, or control interest in the supplier.
18. A supplier must not convey or reassign a supplier number; i.e., the supplier may not sell or allow another entity to use its Medicare billing number.
19. A supplier must have a complaint resolution protocol established to address beneficiary complaints that relate to these standards. A record of these complaints must be maintained at the physical facility.
20. Complaint records must include: the name, address, telephone number and health insurance claim number of the beneficiary, a summary of the complaint, and any actions taken to resolve it.
21. A supplier must agree to furnish CMS any information required by the Medicare statute and regulations.
22. All suppliers must be accredited by a CMS-approved accreditation organization in order to receive and retain a supplier billing number. The accreditation must indicate the specific products and services, for which the supplier is accredited in order for the supplier to receive payment for those specific products and services (except for certain exempt pharmaceuticals).
23. All suppliers must notify their accreditation organization when a new DMEPOS location is opened.
24. All supplier locations, whether owned or subcontracted, must meet the DMEPOS quality standards and be separately accredited in order to bill Medicare.
25. All suppliers must disclose upon enrollment all products and services, including the addition of new product lines for which they are seeking accreditation.
26. A supplier must meet the surety bond requirements specified in 42 CFR § 424.57 (d).
27. A supplier must obtain oxygen from a state-licensed oxygen supplier.
28. A supplier must maintain ordering and referring documentation consistent with provisions found in 42 CFR § 424.516(f).
29. A supplier is prohibited from sharing a practice location with other Medicare providers and suppliers.
30. A supplier must remain open to the public for a minimum of 30 hours per week except physicians (as defined in section 1848(j) (3) of the Act) or physical and occupational therapists or a DMEPOS supplier working with custom made orthotics and prosthetics.

Signature_____ **Date**_____

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***** PLEASE TAKE THIS DOCUMENT HOME WITH YOU*****

NOTICE OF PRIVACY PRACTICES FOR

AMERICAN LIMB & ORTHOPEDIC COMPANY OF VALPARAISO

This summary briefly describes important information contained in our Notice of Privacy Practices. We encourage you to take the time to read the complete notice, which is available at www.americanlimbvalparaiso.com

Our Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Your "protected health information" means any of your written and oral health information, including your demographic data that can be used to identify you. This is health information that is created or received by your health care provider, and that relates to your past, present or future physical or mental health or condition.

This notice will let you know about the various ways we use and disclose your medical information, describe your rights and our obligations with respect to the use or disclosure of your medical information. We will also ask that you acknowledge receipt of this notice the first time you come to or use any of our facilities, because the law requires us to make a good faith effort to obtain your acknowledgement.

We are required by law to:

Make sure that any medical or health information that we have that identifies you is kept private, and will be used or disclosed only in accord with our Notice of Privacy Practices and applicable law.

Give you the complete Notice of our legal duties and our privacy practices; and abide by the terms of the Notice of Privacy Practices that is in effect from time to time.

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*** PLEASE COMPLETE AND RETURN TO THE FRONT DESK AFTER APPOINTMENT ***

PATIENT SATISFACTION SURVEY

Please circle your answer

1	Were you able to obtain a convenient appointment?	YES	NO
2	Was our office staff courteous and friendly?	YES	NO
3	Did you see your practitioner within 15 minutes?	YES	NO
4	Was our office and patient room clean and comfortable?	YES	NO
5	Did your practitioner spend enough time with you and answer all your questions to your satisfaction?	YES	NO
6	Were you given sufficient information on how to use, clean and care for your device?	YES	NO
7	Was your device delivered in a timely manner?	YES	NO
8	Were you satisfied with the overall fit, quality, and comfort of your device?	YES	NO
9	Were you informed about what to do if you have any problems with your device?	YES	NO
10	Were our billing and payment policies discussed during your visit?	YES	NO
11	Would you refer a friend or family member to us?	YES	NO

Please provide any other comments or thoughts which will help us serve you better:

Signed (optional) _____ Date: _____

THANK YOU!

AMERICAN LIMB & ORTHOPEDIC COMPANY OF VALPARAISO