NORTH SHORE LONG ISLAND ORTHOTICS & PROSTHETICS

Patient Name: _____ Date: ___/___/____

Height: _____ Weight_____ Age: _____

Diagnosis:_____

Known allergies:_____

Diabetic or insensate: _____

Date of Amputation:_____

Device: _____

Model: _____

Right / Left / Bilateral

Muscle Group	Strength	Notes
Hip Flexors	0 / 1 / 2 / 3 / 4 / 5	
Hip Extensors	0 / 1 / 2 / 3 / 4 / 5	
Adductors	0 / 1 / 2 / 3 / 4 / 5	
Abductors	0 / 1 / 2 / 3 / 4 / 5	
Quads	0 / 1 / 2 / 3 / 4 / 5	
Hamstring	0 / 1 / 2 / 3 / 4 / 5	
Plantar Flexors	0 / 1 / 2 / 3 / 4 / 5	
Dorsi Flexors	0 / 1 / 2 / 3 / 4 / 5	

Comments:

_____

_____

_____

_____

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NAME: _____ SS#: _____/_____/_____
ADDRESS: _____ CITY: _____STATE: _____ ZIP: _____
HOME PHONE: (_____) _____ WORK PHONE (_____) _____ CELL PHONE: (_____) _____
DATE OF BIRTH: _____/_____/_____ AGE: _____ OCCUPATION: _____
EMPLOYER: _____ SPOUSE'S/PARENT'S/GUARDIAN NAME: _____
EMPLOYER ADDRESS: _____ CITY: _____
STATE: _____ ZIP: _____ SEX: ( ) M ( ) F MARITAL STATUS: single / married / divorced / widowed / other

MEDICAL EMERGENCY CONTACTS: NAME: _____ PHONE: (____) _____
NAME: _____ PHONE: (____) _____
REFERRED BY: (Circle 1) DOCTOR / YELLOW PAGES / INS. PLAN / FRIEND / FAMILY / OTHER: _____

DR. OR FRIEND'S NAME: _____ PHONE NUMBER: (_____) _____
ADDRESS: _____STATE: _____ ZIP: _____
FAMILY PRACTITIONER (OMIT IF ABOVE):_____
ADDRESS: _____STATE: _____ ZIP: _____

HEALTH INSURANCE INFORMATION: PRIMARY INSURANCE NAME: _____
NAME OF INSURED: _____
DATE OF BIRTH: _____/_____/_____ INSURANCE ID#:_____ SS# OF INSURED: _____/_____/_____
CERTIFICATE #:_____ GROUP #: _____ EMPLOYER/GROUP NAME: _____
AMOUNT OF DEDUCTIBLE: _____ HAS THIS BEEN MET? YES /NO

HEALTH INSURANCE INFORMATION: SECONDARY INSURANCE NAME: _____
NAME OF INSURED: _____
DATE OF BIRTH: _____/_____/_____ INSURANCE ID#:_____ SS# OF INSURED: _____/_____/_____
CERTIFICATE #:_____ GROUP #: _____ EMPLOYER/GROUP NAME: _____
AMOUNT OF DEDUCTIBLE: _____ HAS THIS BEEN MET? YES /NO

REASON FOR VISIT: _____

MEDICAL HISTORY: (PLEASE CIRCLE) AMPUTATION / STROKE / BLOOD THINNERS (aspirin, vit. E, Coumadin, Plavix) / PACEMAKER / DEFIBRILLATOR / PREGNANT / IRREGULAR HEARTBEAT / ABNORMAL BLEEDING PROSTHETICS / ABNORMAL SCARRING / NUMBNESS / ASTHMA / SKIN CANCER / DIABETES / SMOKING / ALCOHOL DRUGS / GLAUCOMA / HIV/ HEPATITIS / HEART DISEASE / LEAKY VALVES / SEIZURES / NERVE DAMAGE / EXCESSIVE THIRST /URINATION DIZZINESS / FAINTING / COLD or HEAT INTOLERANCE / HEADACHE / HYPERTENSION / LUNG DISEASE / RECENT OPERATION / HOSPITALIZATION / SWOLLEN GLANDS / DRY SKIN / HIVES / SKIN RASH / LESIONS / WEAKNESS / NIGHT SWEATS / SUDDEN WEIGHT LOSS or GAIN / FEVER:
NONE (Please explain circled items)
_____
_____
ALLERGIES? _____ **NONE** WHAT HAPPENS? _____
MEDICATIONS CURRENTLY TAKING? _____ **NONE**

PLEASE READ THIS STATEMENT AND SIGN BELOW:

ALL INFORMATION I HAVE GIVEN IS TRUE AND COMPLETE. THIS SIGNATURE WILL ALSO BE USED AS "SIGNATURE ON FILE" FOR INSURANCE PURPOSES INCLUDING ANY MEDICAL INFORMATION NECESSARY TO PROCESS THE CLAIM. I HAVE READ AND ACCEPT THE FINANCIAL AND GUARANTEE OF PAYMENT POLICIES AND HEREBY ASSIGN MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO *LIOP* or *NSOP*. I AGREE THAT I AM ULTIMATELY RESPONSIBLE FOR ALL COPAYS, DEDUCTIBLES AND NON-COVERED SERVICES. I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY FOR THE PURPOSE OF PROCESSING CLAIMS WITH MY INSURANCE COMPANY. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL. I GIVE PERMISSION FOR MEDICAL PHOTOGRAPHS TO BE TAKEN AND THEY MAY BE USED FOR EDUCATIONAL PURPOSES, OR OTHERWISE SPECIFIED ON THE PHOTO RELEASE FORM. (PLEASE CROSS OUT THE PREVIOUS SENTENCE IF NOT DESIRED).

SIGNATURE _____ **DATE**_____/_____/_____
* If subject is a minor, this form must be signed by the subject's parent or guardian.

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NORTH SHORE LONG ISLAND
ORTHOTICS & PROSTHETICS

PATIENT FINANCIAL POLICY

Thank you for selecting **LIOP** and **NSOP** for your orthotic & prosthetic care. In order to prevent any misunderstanding concerning the responsibility regarding payment for any orthotic or prosthetic fees, the following information is provided:

Insurance Card(s) and Drivers License:

We require a copy of your insurance card and driver's license or photo id for our records.

Insurance

❖ HMO / PPO / Other Insurance Coverage

It is your responsibility to know and understand your insurance coverage and the requirements for prior authorization, care notification and the billing of orthotics, prosthetics or durable medical equipment as specified under your policy. If you have coverage with a plan that we do not have a prior agreement with, we will prepare and send the claim for you. **All deductible or copayments are due upon delivery of the device(s) provided, unless otherwise advised.** Failure to provide all necessary information may require you to pay in full for your device. **You will be responsible for the denial of any device(s) or service(s) by your insurance carrier that are deemed not medically necessary and/or not covered.**

❖ Medicare

Our facility is participating in Medicare and ***accepts*** Medicare assignment, which is the ALLOWABLE charge approved by Medicare. Medicare will pay 80% of the allowable charges after you pay for your annual part B deductible. You are responsible for any amounts applied to your deductible and the 20% coinsurance. If you have other insurance, we will submit as a courtesy (please refer to the paragraph above regarding any insurance billed other than Medicare or Medicaid).

❖ Medicaid

Our facility is participating in the Medicaid program and ***accepts*** Medicaid assignment. It is your responsibility to know whether you are actively covered by Medicaid on the date your device(s) are delivered or service(s) are rendered. **You will be responsible for any services denied by Medicaid if your insurance coverage was not active on said date(s).**

❖ Self Pay Patients

For patients with no insurance, the guarantor is responsible for the bill at the time of service.

Minors

For all services rendered to minor patients, we will hold the parent or guardian accompanying the minor responsible for expenses incurred.

Payments

Payments can be made by cash, check, VISA, MasterCard.

Balances Due

Patient balances are due within 30 days of receipt of statement. There will be a 2% additional charge on any outstanding balance or a $3.00 minimum additional charge on any outstanding balance if payment is not received in thirty (30) days unless previous arrangements have been made in advance with our Billing Office.

Returned Checks and Collections

A charge of $20 will be made for all returned checks. In the event that any action is brought to collection, I agree to pay any reasonable collection costs and/or attorney fees. My signature below indicates my understanding and full responsibility for the balance on my account for any professional services.

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PATIENT FINANCIAL POLICY (continued)

Benefits Assignment

I hereby authorize the assignment of benefits (payments) directly to **LIOP** or **NSOP** for all my insurance claims related to services received. I agree to pay any and all charges that exceed, or are not covered by my insurance. I understand that co-pays, deductibles and non-covered services are due at the time of service.

YOUR SIGNATURE ON PAGE ONE ACKNOWLEDGES REVIEWING AND ACCEPTING THESE TERMS.

Records Release

I authorize the release of any medical information necessary for the purpose of processing claims with my insurance company. I permit a copy of this authorization to be used in place of the original.

YOUR SIGNATURE ON PAGE ONE ACKNOWLEDGES REVIEWING AND ACCEPTING THESE TERMS.

GUARANTEE OF PAYMENT

Provider Name: **Long Island Orthotics and Prosthetics** **North Shore Orthotics-Prosthetics**

I have read and understand the information above. I understand that my insurance company may deny coverage and request that **LIOP** or **NSOP** perform this medical service anyway. I agree to be personally and fully responsible for all charges. I understand that the provider named above is relying on this promise and is rendering services without requiring payment at the time of service based on such reliance.

YOUR SIGNATURE ON PAGE ONE ACKNOWLEDGES REVIEWING AND ACCEPTING THESE TERMS.

EMAIL ALERT

If you would like to receive office announcements, our newsletter or notification of upcoming studies offering payment to patients, please print your name/email below and we will be happy to put you on our contact list

_____ _____

WARRANTY POLICY

At North Shore Orthotics & Prosthetics our warranty covers defects in materials and workmanship for ***thirty days on soft goods and ninety days for all other products*** following the date of delivery. We will repair or replace any defective part(s) of the device at no charge during the warranty period. ***Orthotic & Prosthetic devices are not returnable or refundable once worn outside the office.*** Replacement parts may differ from the original product due to upgrades or changes in device design and technology.

This warranty includes adjustments that are not due to anatomical changes, i.e. loss or gain of weight and realignment.

This warranty will not apply if misuse, accident, alteration, neglect, unauthorized repair, or improper care has damaged the device. Only our facility is authorized to adjust, modify or repair the device or the warranty will be voided. Linings, straps or wear and tear items are not covered under warranty.

Additionally, damage caused by normal wear and tear of the device is not covered. Manufacturer's warranty may apply to certain components. Certain manufacturer's warranty extends beyond ours; however, charges for shipping, handling, and labor apply.
Note: We reserve the right to use existing technology at time of parts replacement/repair, if appropriate.

I understand and agree to the terms of **LIOP and **NSOP** Warranty Policy.

YOUR SIGNATURE ON PAGE ONE ACKNOWLEDGES REVIEWING AND ACCEPTING THESE TERMS.

NORTH SHORE LONG ISLAND
ORTHOTICS & PROSTHETICS

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, **LIOP** and **NSOP** may use and disclose Protected Health Information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to **LIOP** and **NSOP** Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. **LIOP** and **NSOP** reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **LIOP** and **NSOP** Privacy Officer.

With my consent, **LIOP** and **NSOP** may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, and insurance items and return calls requesting a call back.

With my consent, **LIOP** and **NSOP** may mail to my home or other designated location any items that assists the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, **LIOP** and **NSOP** may email to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request **LIOP** and **NSOP** restrict how it uses or discloses my PHI to carry out TPO.
However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to **LIOP** and **NSOP** use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, **LIOP** and **NSOP** may decline to provide treatment to me.

I am aware that **LIOP** and **NSOP** will scan my files and store them electronically on a secured server off-site.

I hereby grant permission to **LIOP** and **NSOP** and/or its authorized representatives to have photographs or videos taken for patient chart, news/social media publication, lecture presentation, advertising and release any legal responsibility or liability thereof.

**I do not wish to be contacted in the following manner (*check all that applies*):

Home Telephone: ( ) OK to leave message with detailed informaiton
Work Telephone: ( ) OK to leave message with detailed information

List any family member we may release medical information to:

Name: _____ Relationship: _____ Phone: (_____) _____

Name: _____ Relationship: _____ Phone: (_____) _____

_____	_____	_____
Patient's Signature	Print Patient's Name	Date
_____	_____	_____
Legal Guardian's Signature	Print name of Legal Guardian	Date

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PATIENT / CLIENT BILL OF RIGHTS

As an individual receiving orthotic and prosthetic services from our Company, let it be known and understood that you have the following rights:

1. To select those who provide you orthotic and prosthetic services.
2. To be provided with legitimate identification by any person or persons who enters your residence to provide home care services for you.
3. To receive the appropriate or prescribed service in a professional manner without discrimination relative to your age, sex, race, religion, ethnic origin, sexual preference or physical or mental handicap.
4. To be dealt with and treated with friendliness, courtesy and respect by each and every individual representing our Company who provides treatment or services for you, and be free from neglect or abuse, be it physical or mental.
5. To assist in the development and planning of your health care program that is designed to satisfy, as best as possible, your current needs.
6. To be provided with adequate information from which you can give your informed consent for the commencement of service, the continuation of service, the transfer of service to another health care provider, or the termination of service.
7. To express concerns or grievances or recommend modifications to your home care service without fear of discrimination or reprisal.
8. To request and receive complete and up-to-date information relative to your condition, treatment, alternative treatments, or risks of treatment.
9. To receive treatment and services within the scope of your health care plan, promptly and professionally, while being fully informed as to our company's policies, procedures, and charges.
10. To refuse treatment, within the boundaries set by law, and receive professional information relative to the ramifications or consequences that will or may result due to such refusal.
11. To request and receive data regarding treatment or services or costs thereof privately and with confidentiality.
12. To request and receive the opportunity to examine or review your medical records.

NORTH SHORE LONG ISLAND ORTHOTICS & PROSTHETICS

SUPPLIER STANDARDS

1. A supplier must be in compliance with all applicable Federal and State licensure and regulatory requirements and cannot contract with an individual or entity to provide licensed services.
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. An authorized individual (one whose signature is binding) must sign the application for billing privileges.
4. A supplier must fill orders from its own inventory, or must contract with other companies for the purchase of items necessary to fill the order. A supplier may not contract with any entity that is currently excluded from the Medicare program, any State health care programs, or from 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. This standard requires that the location is 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. The supplier location must be accessible to beneficiaries during reasonable business hours, and must maintain a visible sign and posted hours of operation.
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 or cell phone 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 must agree not to initiate telephone contact with beneficiaries, with a few exceptions allowed. This standard prohibits suppliers from contacting a Medicare beneficiary based on a physician's oral order unless an exception applies.
12. A supplier is responsible for delivery and must instruct beneficiaries on use of Medicare covered items, and maintain proof of delivery.
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 directly, or through a service contract with another company, 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 supplier standards to each beneficiary to whom it supplies a Medicare-covered item.
17. A supplier must disclose to the government 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 implementing 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 of those specific products and services (except for certain exempt pharmaceuticals). *Implementation date – October 1, 2009*
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. Must meet the surety bond requirements specified in 42 C.F.R. 424.57(c). *Implementation date - May 4, 2009*
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 C.F.R. 424.516(f).
29. DMEPOS suppliers are prohibited from sharing a practice location with certain other Medicare providers and suppliers.
30. DMEPOS suppliers must remain open to the public for a minimum of 30 hours per week with certain exceptions.

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