Pro-Ped SOLUTIONS

Welcome To Our Practice

Personal Information

Phone: _____

Patient Name:_____ Height: _____ft _____in Weight: _____lb

Email: _____

Address: City:_____ State:_____ Zip:_____

_____

Date of Birth:_____/_____/_____ Sex:_____

Social Security Number

_____

Emergency Information

Emergency Contact:_____ Phone:_____

Relationship To Patient:_____

Insurance Information

PLEASE PROVIDE ID & INSURANCE CARD TO BE COPIED AND KEPT ON FILE

Primary

Insurance Co. Name:_____Phone:_____

I.D.#_____Group#:_____ (PPO HMO POS) ← Circle One

Secondary

Phone:_____

Insurance Name:_____

I.D.#_____Group#:_____ (PPO HMO POS) ← Circle One

Who referred you to Advanced Brace?_____ Prescription? Y / N

What is the nature of your visit? _____

Referral/Doctor Information

Referring Doctor/Primary Doctor:

Name:_____ Phone:_____

Clinic:_____ Fax#:_____

Physical Therapist Information

Name:_____ Phone:_____

Clinic:_____ Fax#:_____

Credit Card / Payment Agreement

Patient: _____ Date: ____/____/_____

- If Co Insurance and/or Deductible is owed, I allow Advanced Brace to charge card on file
- If signed ABN, I understand that if Claim is denied by my insurer I will allow Advanced Brace to charge card on file or discuss a two part payment plan
- If agreed on a two payment--payment plan, I understand that I will remain responsible for the charges and additional finance charges should my credit card be canceled or otherwise made unavailable for payment
- I understand that failure to make payments in a timely manner may terminate this agreement and move to collections or collect in full
- I understand that if Advanced Brace has to undertake additional action to collect this debt then I will be responsible for the additional expenses (collection fees, etc.)
* I understand that I am required to sign a credit card sales slip imprinted with my referenced credit card, which will be held on file by Advanced Brace as total owed is never 100% finalized until AFTER the claim has processed by my insurance--I may owe more or I may submit a refund
* I understand if device(s) is abandoned, full payment of device will be charged
* I understand that this agreement will remain in force until the entire balance is paid
- **Due to increased Credit Card fees, there will be a 3% fee if choosing to use a Credit or Debit card**
- I have read and fully understand this agreement

Card #: _____ CVV:_____

Name of Cardholder _____

Expiration Date ____/_____ Circle one: VISA MASTERCARD DISCOVER

I hereby authorize Advanced Brace to charge the referenced credit card account automatically once they have exhausted all they can with my insurance company if my device(s) are denied. If a payment plan is agreed on I authorize them to make the monthly payments.

Cardholder's Signature_____

_____

Office Personnel Portion

Received by Advanced Brace:_____ Date____/____/____

In the event we have to appeal your claim, we will have to submit this form granting us permission to appeal on your behalf.

Patient Consent for My Provider to
File an Appeal on my Behalf with my Health Insurance Plan

Provider Name: Advanced Brace	**Provider Plan ID Number:** 1538348800
Provider Address: 622 FM 517 Road West, Dickinson, TX 77539	
Description of services that may be appealed: DME that is Medically Necessary	**Date(s) services were provided:**

I agree to allow this health care provider to file an appeal on my behalf with the following health plan if there is a question about coverage for the services listed below.

I understand that:

1. If I consent, I will not be able to file my own appeal concerning these same services, nor will any representative I appoint, unless this consent is rescinded in writing.
2. I have a right to rescind this consent at any time. My legal representative has the right to rescind this consent at any time.
3. This consent shall be automatically rescinded if my health care provider does not file an appeal, or stops appealing my case.

I have read this consent or have had it read to me, and it has been explained to my satisfaction.

I understand the information in the consent form, and grant my consent to this provider to file an appeal on my behalf.

Print Patient Name:	**Patient Date of Birth:**	**Health Insurance Company**:
Patient Address:	**Patient Insurance ID Number:**	
Patient Signature:	**Signature Date:**	

The above named enrollee is unable to sign this consent form because of the following reasons and I consent for the above named enrollee:

Print Representative Name:	**Relationship to the Patient:**
Representative Signature:	**Signature Date**:

Print Witness Name:	**Witness Signature:**	**Signature Date:**

Release of Medical Records

I, _____give Pro-Ped Solutions on the date of _____/_____/_____permission to use my signature to obtain/request medical records at any time from my Physician and or Hospital.

I understand that they may need to obtain such records in the future for insurance purposes.

x_____

If a minor or unable to sign, the individual signing must sign & state relationship to Patient.

Relationship: _____

Patient Photo Release Form

I, _____hereby authorize Pro-Ped Solutions, to take photographs and/or videos of my device.

I understand that the photographs and/or videos will be used as a record of my care, and may be used for educational purposes, demonstrations, advertising further and understand that if the photographs and/or videos are used in any publication or as a part of a demonstration, my name or other identifying information will **not** be used.

_____The above stated is fine and will allow photographs and or videos

I do not want any photographs or videos used for publication purposes

Sign Date_____

Print name & relationship if parent or guardian _____

_____

Pro – Ped Solutions

Patient Policies

Warranty Policy

The warranty period for custom devices is 90 days for workmanship and materials. Although Advanced Brace Orthotics & Prosthetics cannot be responsible for physiological or anatomical changes in a patient's medical condition, we will attempt to maintain proper fit during this period. Additions of components, straps, lifts, etc. prescribed by a physician will incur a charge. There will be a separate charge for adjustments or repairs that are made as a result of abuse or tough wear, as may occur from sporting, vocational, or unusual activities.

Since Orthotics and Prosthetics are prescribed at the direction of a physician, and are often custom-fabricated for the anatomy and medical condition of each individual, they cannot be returned for credit or refund. Prescribed "off the shelf" items cannot be returned for hygienic reasons.

Please communicate any problems or discomfort you are experiencing to your practitioner immediately to allow us to resolve these problems as efficiently and quickly as possible. We will make every attempt to meet your needs.

Advanced Brace Orthotics & Prosthetics is aware of the importance of wearing the device that has been provided. In the event that a prosthesis is in the need of immediate repair, it will receive the highest priority and every effort will be made to repair or replace the device as soon as possible. In the event that an urgent need arises concerning your device, please contact the office that provided you the device. An Advanced Brace Orthotics & Prosthetics representative will return your call as soon as possible, during normal business hours.

Payment and Policy Agreement

Your insurance policy is a contract between you and your insurance company to help you meet medical expenses. Because benefits can vary greatly, it is not possible for Advanced Brace Orthotics & Prosthetics to provide services on the basis that your insurance company will pay all charges.

Advanced Brace Orthotics & Prosthetics can in no way guarantee coverage. Benefits are determined by your insurance plan at the time your claim is processed. All benefit calculations are only an estimate, based on information obtained from your insurance company. The actual Total Patient's Responsibility may be different from what was previously estimated by Advanced Brace Orthotics & Prosthetics.

To prevent any misunderstanding about medical insurance, we wish to point out that: (1) Payment for all medical services furnished are the responsibility of the patient; (2) Deductibles, co-payments, and/or other patient responsibility amounts are due at the time services are rendered; (3) For deductibles, co-insurance and non-covered custom-made devices **fifty percent (50 %)** of the balance is due at the casting appointment, with **the balance due at the time of delivery.** In the event payment is not collected in full upon pick up, and **if payment is not received within 30 days of receipt of device Credit Card on file will be charged remaining balance and a receipt will be mailed to address on file**; (4) Advanced Brace Orthotics & Prosthetics will bill your insurance company as a courtesy to you; however, Advanced Brace Orthotics & Prosthetics is not responsible for non-payment from the insurance company; (5) If, due to unforeseen circumstances, additional procedures and/or treatments are necessary beyond what has been previously approved, patients must make arrangements for payment; (6) Patients are expected to keep their accounts current while waiting for their insurance company to remit payment. (7) **Due to increased Credit Card fees, a 3% charge will be added to all card payments.**

In consideration of The Company's efforts to supply patients with products and/or services to the patient, the patient or guarantor agrees that each of them is responsible for payment. In some cases, insurance companies require our chart notes to match the physician's notes. For this reason, we may need to wait to receive your physician's notes before proceeding with your device.

Payments may be made by check, money order, Visa, Discover or MasterCard. A $20.00 fee will be assessed for any check returned for any reason.

Patient Complaint Process

We are committed to ensuring you are completely satisfied with the services and care you receive at Advanced Brace Orthotics & Prosthetics. However, if for any reason you wish to file a complaint, any staff member can assist you in this confidential matter. You will be asked to complete a "Patient Complaint Form" to assist us in understanding your complaint or concern fully. Once the form is received, a company representative will investigate the complaint thoroughly and take the necessary actions to satisfy your complaint. (You will be notified of the receipt and actions taken, as appropriate, within 30 business days of receipt of your Patient Complaint Form.) You can also call our Compliance Officer at 713-882-0142 or the Department of Health & Human Services at 512-458-7111.

Patient Bill of Rights

Each patient has the right to:

- Receive complete and current information regarding his/her diagnosis, treatment and prognosis in terms he/she can understand. When it is not medically advisable to give the information to the patient, it will be made to the appropriate person on his/her behalf.
- Know the practitioner's name and specialty who is responsible for the coordination of care.
- Receive service regardless of age, race, religion, sex, social status, political belief, disability or diagnosis.
- Privacy and confidentiality regarding information and records about his/her care and may approve or refuse to release information to any individual outside the Advanced Brace Orthotics & Prosthetics as outlined in the notice of Privacy Practices.
- Expect Advanced Brace Orthotics & Prosthetics to make a reasonable response to his/her requests.
- Obtain information on the relationship of Advanced Brace Orthotics & Prosthetics to other health care and related institutions insofar as his/her care is concerned.
- Receive reasonable coordination and continuity of care.
- Know the cost of care and treatment and receive an explanation of his/her financial responsibility upon request.
- Participate in decisions concerning his/her care and to refuse to participate in experimental treatment.
- Express dissatisfaction and suggest changes in any service without coercion, discrimination, reprisal, or unreasonable interruption of service.
- Receive information on Advanced Brace Orthotics & Prosthetics policies for receiving, reviewing, and resolving customer complaints.
- Be fully informed of Advanced Brace Orthotics & Prosthetics policies, procedures, and charges for services including criteria for third party reimbursement and receive an explanation of all forms that are requested to be signed.

Patient Signature

/

/

Patient Name

Date

HIPAA Notice of Privacy Practices

Effective as of April/14/2003
Revised October/ 17/2018
Contact: 864-272-0388

IBIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO IBIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compens:ocion, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made **only with your consent, authorization** or opportunity to object unless required by law. Without your authorization, we are expressly prohibited t0 use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. **We will** not use or disclose any of your protected health information char contains generic information that will be used for underwriting purposes.

You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to **inspect and copy your protected health information (fees may apply)** Pursuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, yo11 may not inspect or copy the following records: Physician notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate,
information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction t0 apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request to receive confidential communications You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information If we deny your request for amendment, you have the right to file a statement of disagreement with us and **we** may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior t0 the date of the request.

You have the right to **receive notice of a breach** - We will notify you if your unsecured protected health information has been breached.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer by phone at 713-882-0142 .

Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

Signature of Acknowledgement: X

Printed Name & Date: _____