BREVARD PROSTHETICS & ORTHOTICS

PATIENT INFORMATION

PT #: _____ NAME: _____ DOB: _____

SS#_____ MARITAL STATUS: _____

ADDRESS _____ CITY, STATE, ZIP: _____

HOME #: _____ WORK #: _____ CELL #: _____
DO WE HAVE YOUR CONSENT TO CONTACT YOU AT EACH NUMBER LISTED ABOVE?
(PLEASE CIRCLE) ◯ YES OR ◯ NO

EMERGENCY CONTACT: _____RELATIONSHIP: _____PH: _____

HEIGHT: _____ WEIGHT: _____ GENDER: MALE OR FEMALE

OTHER MEDICAL CONDITIONS: _____

PRIMARY PHYSICAN: _____ PHONE #: _____

ORDERING PHYSICIAN: _____PHONE#: _____

LEVEL OF AMPUTATION: _____ RIGHT LEFT BILATERAL

DATE OF AMPUTATION: _____ BY DOCTOR: _____

REASON FOR AMPUTATION: _____

****

PRIMARY INS: _____ ID#: _____

SECONDARY INS: _____ID#: _____
****
Has the beneficiary ever received the same or similar supplies/equipment? Yes or No

If yes, list equipment/supplies: _____

Date Purchased: _____

Benefits, Medical Information, Release Authorization and Acknowledgment of Financial Responsibility:
I request my insurance benefits, if any to be paid directly to BREVARD PROSTHETICS & ORTHTOICS, INC. I authorize the release of any information necessary to provide services or process claims. I understand that I am personally responsible for the entire amount of my claim and that insurance benefits may be limited or not covered. In the event that my insurance carrier does not accept assignment of Benefit, or if payments are made directly to me or my representative, I will endorse such payments to BREVARD PROSTHETICS & ORTHOTICS, INC. I agree to notify BREVARD PROSTHETICS & ORTHOTICS, INC. immediately of any change in insurance coverage or status.

I understand that I have the right to request and receive a Notice of Privacy Practices from Brevard Prosthetics.

_____ _____
Patient Signature ***Date***

_____ _____
Responsible Party Signature ***Relationship*** ***Date***

Acknowledgement of Receipt of Notice of Privacy Practices

I certify that I am aware of the privacy practices of **Brevard Prosthetics & Orthotics, Inc.** and may request a copy of the Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of **Brevard Prosthetics & Orthotics, Inc.** health care operations.The Notice of Privacy Practices also describes my rights and **Brevard Prosthetics & Orthotics, Inc.** duties with respect to my protected health information. The Notice of Privacy Practices is posted in **Brevard Prosthetic & Orthotics, Inc. facilities located in:**

Rockledge- 966 US Hwy 1

Melbourne- 1405 S. Valentine Street

Titusville- 2110 S Washington Ave Suite D

Fort Myers- 13240 N. Cleveland Ave Suite 1

Port Charlotte- 21216 Olean Blvd Suite 1

Brevard Prosthetics & Orthotics, Inc reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, asking for one at the time of my next appointment.

NOTE: You can also read Brevard Prosthetics & Orthotics' Notice of Privacy Practices by clicking HERE

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority

BREVARD PROSTHETICS & ORTHOTICS INC

WAIVER OF LIABILITY

Supplier's Notice:

Medicare and Insurance Companies will only pay for services it determines to be "reasonable and necessary" under Section 1862(a) (1) of the Medicare law. If your Insurance provider determines that a particular service, although it prescribed by your physician and would otherwise be covered, is not "reasonable and necessary" under your Insurance program standards, they will deny payment for that service.

Beneficiary's Acknowledgment and Agreement to Pay: Brevard Prosthetics & Orthotics, Inc. for services rendered.

In signing this form, I understand there is a possibility that Medicare or my insurance company may deny payment for the services identified above, for the reason stated. If the Medicare or the Insurance Company denies the payment, I agree to be personally and fully responsible for payment.

Signed, _____ Date_____
(Beneficiary signature)

BREVARD PROSTHETICS & ORTHOTICS, INC

TO OUR MEDICARE PATIENTS

As providers of prosthetic services to Medicare eligible beneficiaries, we agree to adhere to the Medicare DMEPOS Supplier below. If you have questions regarding these standards, or any of our other office policies, we will be happy to answer them for you.

THE SUPPLIER:

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. 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, and 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.
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. The standard prohibits suppliers from calling beneficiaries in order to solicit new business.
12. A supplier is responsible for delivery and must instruct beneficiaries on the 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 action 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 service (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 ©. *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.

I have read these standards and have been offered a copy for my records

Patient's Signature_____ Revised – 2/02/11

966 US Hwy 1
Rockledge, FL 32955
(321) 638-0262
FAX (321) 638-4559

Brevard Prosthetics & Orthotics

I hereby consent and authorize Brevard Prosthetics & Orthotics, Inc. to Photograph me wearing my Prosthetic or Orthotic device for the sole use of Brevard Prosthetics & Orthotics, Inc. The image(s) will be used for the sole purpose of Proof of delivery and justification to your Insurance companies. The image(s) will be retained by Brevard Prosthetics & Orthotics in your personal File.

_____ _____

Signature **Date**

_____

Printed Name

_____ _____

Witness Signature **Date**

_____

Witness Printed Name