Please Print

■ INFORMATION ON THE PATIENT

Last Name | First Name | M.I. | Social Security Number

Street Address | City | State | Zip | Home Phone Number

M ☐ F ☐ Sex | Single ☐ Married ☐ Other ☐ Marital Status | / / Month / Day / Year of Birth | Referring Physician's Name | Phone Number

Local Friend or Relative Not Living With You | Street Address | City | Phone Number

EMAIL ADDRESS: | Cell # ( )

■ INFORMATION ON THE PERSON FINANCIALLY RESPONSIBLE FOR THE SERVICES (Self, Parent or Guardian)

Last Name | First Name | Date of Birth | Relationship to Patient | Soc. Sec. Number

Street Address | City | State | Zip | Home Phone Number

Employer | Work Phone Number | How Long Employed?

Employer Address | City | State | Zip

Spouse's Last Name | First Name | M.I. | Soc. Sec. Number

Spouse's Employer | Work Phone Number | How Long Employed?

■ INSURANCE INFORMATION (If you provide **insurance cards** for photocopying, you **need not complete** this section)

PRIMARY Insurance Information	**SECONDARY** Insurance Information*
Name of Policyholder	Name of Policyholder
Insurance Company or Health Plan Name	Insurance Company or Health Plan Name
( ) Insurance Company or Health Plan Phone Number	( ) Insurance Company or Health Plan Phone Number
Plan or Group Number	Plan or Group Number
Identification Number (Medicare, Medicaid, CHAMPUS, Member ID, etc.)	Identification Number (Medicare, Medicaid, CHAMPUS, Member ID, etc.)

* *Please complete **page 2** of the Patient Information Form if you have additional insurance or **workers compensation** coverage.*

FINANCIAL RESPONSIBILITY, SERVICE AND RELEASE OF INFORMATION AUTHORIZATION

I agree to be personally financially responsible for the services rendered to the above "Patient," unless such is precluded by third-party payor. I understand that it is not possible for this provider to determine the extent to which services will be covered by a third-party payor prior to the delivery of such services. I request that payment of authorized benefits be made on my behalf to this provider for any services it furnished to me. I authorize this holder of medical information about me to release to appropriate third-party payors and their agents any information needed to determine my benefits. I hereby authorize orthotic/prosthetic services for the above "Patient" at any time when prescribed by a physician. My signature to this document may be used as the "Signature on File" for the appropriate billing to a third-party payor.

Signature of Patient | Signature of Parent or Guardian | Date

CERTIFIED LIMB AND BRACE

FINANCIAL AGREEMENT

Welcome to our office. We request that all patients or responsible parties provide a copy of your driver's license and all insurance cards so that we may make copies for our permanent record.

If you have medical insurance:
We will contact your insurance company to determine eligibility and benefits. Your insurance company may require authorization, pre-determination, or some other form of approval/notification prior to delivery. If that is the case we will provide our portion of the documentation necessary for approval. If information is required from the referring physician or the insured, we will let you know what information is needed.

Most insurance companies have a disclaimer stating "verification of benefits is not a guarantee of payment. Benefits will be determined at time of claim processing". In other words, the insurance company will decide after you receive services whether or not payment of those services will be made. Medical insurance coverage is a contract between you and your insurance company. We are not a party to this contract. We will not participate in disputes between you and your insurance company regarding coverage or payment for services other than to supply general information. You are ultimately responsible for the payment of your account. If the insurance company denies the claim for a plan provision, you will be responsible for the balance.

If you would like to make financial arrangements for the balance due please let us know.

I acknowledge that I have read and agree to the above policy:

Signature: _____ Date: _____

Witness: _____ Date: _____

CERTIFIED LIMB & BRACE
3227 Portland Avenue
Shreveport, LA 71103

Patient Acknowledgement

Patient Name_____ Date of Birth_____

Address: _____ Telephone_____

_____

_____

I acknowledge that I have received a copy of the Privacy Practices of Certified Limb & Brace.

_____ Date_____
Patient or Legal Guardian

_____ Date_____
Witness

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many healthcare professionals who contribute to my care
- a source of information for applying my diagnosis and evaluation to my bill
- a means by which a third – party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and I may obtain a revised notice of privacy practices by calling the office and requesting that a copy be sent in the mail or I may request one at my next appointment. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

☐ No restrictions

☐ I request the following restrictions to the use and disclosure of my health information:

_____

_____

_____ _____

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE WITNESS

_____ _____

DATE

.....

Office Personnel only:

Restriction ☐ Accepted ☐ Denied

_____ _____ _____

Signature Title

10/1/14

MEDICARE 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.

Certified Limb & Brace
Quality Checked

Patient Intake Form Date: _____

PATIENT INFORMATION

Patient Name:

Address:

Phone Number(s):

Personal Info: Birthday: Age: Height: Weight:

AMPUTATION INFORMATION

Amputation Location: ☐ Right side ☐ Left side

Amputation Location: ☐ Below knee ☐ Above knee ☐ Below elbow ☐ Above elbow

Date of Amputation:

Reason for Amputation:

Referring Physician:

Living Conditions: ☐ Home with no assistance ☐ Home with assistance ☐ Do not live at home

Medical History: ☐ Heart ☐ Kidney ☐ Dialysis ☐ Frequent swelling

☐ Stroke ☐ Diabetes ☐ Circulatory ☐ Sound limb compromised (accident)

Other medical conditions:

PROSTHESIS INFORMATION

How old is your prosthesis?

Where was your prosthesis made?

Please rate your present prosthesis ☐ Very good ☐ Good ☐ Average ☐ Below average ☐ Very bad

CERTIFIED LIMB AND BRACE

Satisfaction Survey

_____
Type of Prosthesis or Orthosis

As our patient, your opinions about our services matter to us. By completing this survey, you can let us know what we did right and what needs improvement. Please leave this with your Practitioner, the Office Administrators or mail to: Certified Limb and Brace P.O. Box 33333 Shreveport, LA 71130-3333.

For each question, circle the rating that best reflects your views:

5=highest rating/excellent; 3=satisfactory rating/average; 1=lowest rating/poor

1. How promptly were you seen by the Practitioner when you came in for your visit?
   (Very promptly) (Very late)
   5 4 3 2 1
2. Did the Practitioner seem concerned and interested in you and your rehabilitation needs?
   (Very concerned) (Didn't seem to care)
   5 4 3 2 1
3. Was the Practitioner professional in appearance and behavior?
   (Very professional) (Very unprofessional)
   5 4 3 2 1
4. How well did your Practitioner explain how to put on, take off, and take care of your device?
   (Explained very well) (Explained poorly)
   5 4 3 2 1
5. How well does your device fit?

   (Fits very well) (Fits poorly)

   5 4 3 2 1

6. How many hours a day do you wear your device? _____ Hours (Please estimate)

7. Considering its limitations, how well does your device function?
   (Functions very well) (Functions poorly)
   5 4 3 2 1
8. Please rate on a scale of 1 to 10 your access to services taking into consideration where you live and where you are seen and whether or not your method of payment is accepted.
   1 2 3 4 5 6 7 8 9 10
9. Was our receptionist pleasant and helpful to you during your visit?
   (Very pleasant/Helpful) (Not helpful/unpleasant)
   5 4 3 2 1

10. How well did our staff explain to overall costs of your device and what you personally owe?

(Explained very well) (Explained poorly)

5 4 3 2 1

11. Were your questions answered in a timely manner?

(Answered timely) (Not answered timely)

5 4 3 2 1

12. If you've telephoned our facility, how would you rate our phone service?

(Very courteous) (Not courteous)

5 4 3 2 1

13. Overall, were you satisfied with the services you received?

(Very satisfied) (Not satisfied)

5 4 3 2 1

14. How likely are you to choose our services again?

(Very likely) (Very unlikely)

5 4 3 2 1

15. How can we improve our services? _____

_____

Name: (Optional) _____

Date of your most recent visit: _____

If you would like to be contacted, please provide a telephone number for us to call: _____

Revised 1/2014

Certified Limb & Brace

Quality Checked

Certified Limb and Brace

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

I. Our Legal Responsibilities

This Privacy Notice is being provided to you as a requirement of federal law known as the **Health Insurance Portability and Accountability Act (HIPAA).** The Privacy Notice describes how we may use and disclose your protected health information to carry out treatment, payment or healthcare operations and for other purposes that are permitted or required by law. It also describes your rights to access and control protected health information in some cases. Your "protected health information" means any written and oral health information about you, including demographic data that can be used to identify you.

We are required by law to follow the privacy practices that are described in this Notice while it is in effect. As permitted by law, we reserve the right to change our privacy practices and the terms of this Notice at any time. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available to you at your next visit to our office. You may request a copy of our Notice at any time.

II. Examples of Uses and Disclosures of Protected Health Information

Our Practice may use your protected health information for purposes of providing treatment, obtaining payment for treatment and conducting healthcare operations.

A. Treatment. We may use or disclose your health information to a physician or other healthcare practitioner providing treatment to you. We may also disclose medical information about you to people who may be involved in your medical care, which may include your family member, or other personal representatives.

B. Payment. We may use and disclose your health information to obtain payment for services we provide to you. For example, we may need to give your healthcare information, regarding the services you received from us, to obtain payment or reimbursement for the services.

C. Healthcare Operations. We may use and disclose your health information in connection with healthcare operations. Healthcare operations include such activities as: quality assessment and improvement activities, training programs, medical reviews, and employee review activities, licensing and credentialing programs.

D. Uses of Information. We may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting area when the Practitioner is ready to see you or to contact you to remind you of your appointment.

E. Your Authorization. In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us a written authorization, you may revoke it, in writing, at any time. Your revocation will not affect any use or disclosures permitted

by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

F. To Your Family and Friends. We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

G. Persons Involved in Care. Unless you object, we may use and disclose your protected health information to notify or assist in notifying a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up devices and supplies or other forms of health information.

H. Market Health-Related Services. We will not use your health information for marketing communications without your written authorization.

I. Required by Law. We may use and disclose your health information when we are required to do so by law.

J. Abuse and Neglect. We may disclose your health information to public authorities as allowed by law to report abuse or neglect. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

K. National Security. We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials, health information required for lawful intelligence, counter-intelligence, and other national security activities. We may disclose to correctional institutions of law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

III. Your Health Information Rights

You have the following rights regarding medical information we maintain about you:

A. Right to Inspect and Copy. You have the right to inspect and copy your protected health information, with limited exceptions. The request to review your records must be made in writing to the Privacy Officer. You may obtain a form to request access by using the contact information at the bottom of this Notice. We may deny your request under certain circumstances. If you request a copy of your information, we may charge you a fee for the costs incurred by us in complying with your request. If you prefer, we may prepare a summary of an explanation of your health information for a fee.

B. Right to an Accounting Disclosure. You have the right to receive a list of instances in which we, or our business associates, disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities. If you request this accounting more than once in a twelve month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

C. Right to Request Restrictions. You have the right to request that we place additional restrictions on our use and disclosures of your protected health information. We are not required to agree with these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

D. Right to Request Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or to an alternative location. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or locations request.

E. Right to Request an Amendment. You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we deny your request for amendment, you have the right to file a Statement of Disagreement and we may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal.

F. Right to a Paper Copy of This Notice. You have a right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

IV. Questions and Complaints

If you have any questions, would like additional information, or want to report a problem regarding the handling of your information, please contact us. If you believe that your rights have been violated, you may file a complaint with the Secretary of the United States Department of Health and Hospitals. We will provide you with the address to file your complaint upon request. To file a complaint with our office, contact Theresa Quinn at 318-636-9145. We support the right to the privacy of your protected health information. We will not retaliate in any way if you choose to file a complaint with us or with the U. S. Department of Health and Human Services.