Baker Orthotics and Prosthetics

Reason for Visit: ____ □ Left □ Right

Name: (Last) __________________________ **(First)** ________________ **(M.I.)** ____

Date of Birth: ____/____/____ **Gender:** □ Male □ Female **SS#:** ________-______-________

Marital Status (Circle One): M D W S Other **Home Phone:** (____) ______-________

Cell Phone: (____) _______-_______ **Other:** (____) _______-_______

Home Address: __________________________ **Email:** ______________________

City/State: ________________________/_______ **Zip Code:** __________

□ **Retired** □ **Disability** □ **Unemployed** □ **Student** □ **Employed Part Time** □ **Full time** □ **Other:** ___________

Employer: _____________________________ **Employer Phone:** (____) _______-_______

Employer Address: ____________________ **City/State:** __________/___ **Zip Code:** _________

Emergency Contact: ______________ **Relationship:** __________ **Phone:** (____) _______-_______

Name of: Spouse/Parent/Guardian: ______________________ **Phone:** (____) _______-_______

Address: __________________________ **City/State:** __________/___ **Zip Code:** _________

Nearest friend/relative not living with you: ________________ **Phone:** (____) _______-_______

Is injury related to: □ **WORK** □ **AUTO ACCIDENT** □ **NON-ACCIDENT** □ **OTHER:** ______________

If "WORK" complete the following: Date of Injury: ____/____/____ **Claim #:** ________________

Employer name at time of injury: ____

Address: __________________________ **City/State:** __________/___ **Zip Code:** _________

Phone: (____) _______-_______ **Supervisor or contact person at employer:** ________________

Work Comp Insurance Name: ____

Address: __________________________ **City/State:** __________/___ **Zip Code:** _________

Adjustor's Name: ________________________________ **Phone:** (____) _______-_______

WE FILE YOUR INSURANCE FOR YOUR CONVENIENCE. VERIFICATION OF BENEFITS OR PRE-CERTIFICATION DOES NOT GURANTEE PAYMENT OF A CLAIM. WE ALLOW SIX WEEKS FOR YOUR INSURANCE TO PAY, THEN PAYMENT IN FULL IS YOUR RESPONSIBILITY. THANK YOU IN ADVANCE FOR YOUR COOPERATION!

INSURANCE INFORMATION:

How do you intend to pay your portion? □ **Cash** □ **Check** □ **Credit Card (Type:** ____________**)**

Primary Insurance: ____

Address: __________________________ City/State: __________/___ Zip Code: _________

Phone: (____) _______-_______ Policy #: ____________________ Group #: ____________

Name of insured: ____________________________________ Date of Birth: ____/____/____

Relation: □ Self □ Spouse □ Child Insured's SS#: ________-______-________

Insured's employer: ______________________________

Secondary Insurance:____

Address: ____________________________________ City/State: ____________/___ Zip Code: __________

Phone: (____) _______-_______ Policy #: ___________________________ Group #: _________________

Name of insured: ____ Date of Birth: ____/____/____

Relation: □ Self □ Spouse □ Child Insured's SS#: __________-_______-__________

Referring Physician: ____ **Phone:** (____) _______-_______

Primary care physician: ____ **Phone:** (____) _______-_______

Diagnosis of illness or injury: ______________________ □ **Left** □ **Right** **Date of onset:** ____/____/____

Height: ___________ **Weight:** ___________

Are you diabetic? Y N Diabetic Physician: ________________________ **Phone:** (____) _______-_______

Have you received a device or any other type of orthosis or prosthesis directly related to this condition in the past? □ **YES** □ **NO** **If yes, when:** ____/____/____ **please explain what you have, and from whom:**____

____

I certify that the above is true and accurate: ________________________________ **Date:** ____/____/____

I give Baker O&P permission to contact me via phone, email or US mail for the purposes of my future care and/or advancements in technology regarding this service.

____ _______________________________

Patient Signature **Date**

ASSIGNMENT OF BENEFITS

I request that payment of authorized Medicare or other third party payer benefits be made to Baker O&P Enterprises Inc. ("Baker") for any services furnished to me by Baker. I hereby authorize Baker to release any medical or other information needed to process any claim for payment of services provided to me by Baker. I further authorize Baker to release any specific other medical information needed by any other healthcare provider treating me for the specific medical condition related to the services provided to me by Baker. I agree to be responsible for payment of any amounts not covered by my insurance plan or any amounts remaining after my insurance plan has made payment, including all deductibles, co-payments and coinsurance.

____ _______________________________

Beneficiary Signature or Beneficiary Representative **Date**

If Beneficiary Representative, state relationship and reason why beneficiary cannot sign:

If Representative, you must show your complete address:

____ _______________________________

____ _______________________________

Form Revised on 10/19/2010

Patient / Client Bill of Rights

As an individual receiving orthotic and prosthetic services from Baker Orthotics & Prosthetics, 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.

I have received and understand the rights afforded me as a patient/client.

____________________________ ____________________

Signature of Patient/Client Date

____________________________ ____________________

Signature of Practitioner Date

09/2006

Baker Orthotics and Prosthetics

Service Policy:

Our services are provided by qualified licensed professionals to meet your individual needs. Patient evaluation, consultation, design, fitting, and follow up adjustments for the Medicare mandated guideline of ninety (90) days are provided at no additional cost to you unless there is a change in your physical condition.

You are responsible for any adjustment, modification, or repair charges after ninety days. These services may be necessary for reasons such as changes to your body volume status or functional capacity, wear and tear, or damage.

You will also be responsible for any charges that may be necessary to replace your device or a component part. In these cases, we will honor any manufacturer warranty which may exist so that your responsibility may be limited to labor charges only.

If your insurance is provided by a managed care insurer (HMO, PPO, etc.) or Medicaid, you may need to obtain a referral from your primary care physician.

Return Policy:

We will make all reasonable attempts to assure a proper fit and functionality of Custom made and / or custom fitted orthotic and prosthetic devices. Due to the single-use custom nature of these devices, product returns are not accepted.

Unused prepackaged soft goods may be exchanged or returned for credit.

We strive to meet your expectations and appreciate the opportunity to serve your needs.

______________________________ ______________________

Patient Signature **Date Signed**

____

Patient Name (PLEASE PRINT)

______________________________ ______________________

Parent/Legal Guardian/Patient Representative Signature **Relationship to Patient**

____

Parent/Legal Guardian/Patient Representative (PRINT)

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.

PLEASE REVIEW IT CAREFULLY

Uses and Disclosures

Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of evaluations will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations: Your health information may be used as necessary to support the day-to-day activities and management of Baker Orthotics & Prosthetics. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement: Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department. We may also disclose your medical information if we believe that you have been a victim of abuse, neglect or domestic violence to the proper state agency authorized to receive such information.

Required by law: Your medical record may be used or disclosed to the extent that this is required by law.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information on the treatment and management of your medical condition or new technology that you may find to be of interest. We may also send you information describing other health-related goods and service that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- the right to request restrictions on the use and disclosure of your protected health information
- the right to receive confidential communications concerning your medical condition and treatment
- the right to inspect and copy your protected health information
- the right to amend or submit corrections to your protected health information
- the right to receive an accounting of how and to whom your protected health information has been disclosed

- the right to receive a printed copy of this notice

BAKER ORTHOTICS & PROSTHETICS DUTIES

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

RIGHT TO REVISE PRIVACY PRACTICES

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

REQUESTS TO INSPECT PROTECTED HEALTH INFORMATION

As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting Mattie Stevens.

COMPLAINTS

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Privacy Officer
Baker Orthotics & Prosthetics
810 Lipscomb Street
Fort Worth, TX 76104

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.

EFFECTIVE DATE

This Notice is effective on or after April 14, 2003.

COMPLAINTS

As listed below, health information privacy complaints may be filed with the Secretary of DHHS and should be addressed to him at the OCR (Office for Civil Rights) regional office that is responsible for matters relating to the Privacy Rule arising in the state or jurisdiction where the covered entity is located. Complaints may also be filed via email at the address noted below.

Where to File Complaints Concerning Health Information Privacy

For complaints including entities located in Arkansas, Louisiana, New Mexico, Oklahoma, or Texas:
Region VI, Office for Civil Rights, Department of Health and Human Services, 1301 Young Street, Suite 1169, Dallas, TX 75202. Voice phone (214) 767-4056. FAX (214) 767-0432. TDD (214) 767-8940.

For all complaints filed by email, send to: OCRComplaint@hhs.gov.

FOR FURTHER INFORMATION CONTACT: Lester Coffer, Office for Civil Rights, Department of Health and Human Services, Mail Stop Room 506F, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201. Telephone number: (202) 205-872

Consent for Use and Disclosure of Protected Health Information

Use and Disclosure of Your Protected Health Information

Your protected health information will be used by Baker Orthotics & Prosthetics or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice. This includes obtaining protected health information from covered entities (i.e. physicians, insurance companies, etc.) for such purposes.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your protected health information.

Baker Orthotics & Prosthetics may or may not agree to restrict the use or disclosure of your protected health information.

If Baker Orthotics & Prosthetics agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices

Baker Orthotics & Prosthetics reserves the right to modify the privacy practices outlined in the notice.

Signature

I have reviewed this consent form and give my permission to Baker Orthotics & Prosthetics to use and disclose my health information in accordance with it.

____

Name of Patient (Print or Type)

____

Signature of Patient Date

____

Signature of Patient Representative

____

Relationship of Patient Representative to Patient

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received a copy of The Notice of Privacy Practices for Baker Orthotics & Prosthetics.

______________________________________ __________________

Signature of Patient or Authorized Representative Date

If Representative, print name and relationship:

____

UNABLE TO OBTAIN PATIENT'S SIGNATURE OF RECEIPT. COPY OF NOTICE WAS LEFT WITH PATIENT. THE REASON SIGNATURE WAS NOT OBTAINED:

____

____

____

_____________________________________ ____________________

Clinician's signature Date

061005

PATIENT SATISFACTION SURVEY

Date: ___________________
Patient's Name (optional): ____
Name of person completing survey (optional): _______________________________________
Telephone Number (optional): ______________________________ Age of patient: ________
Type of device worn (**required**): ____

Please rate us on a scale of 1-5 with **5 EXCELLENT** and **1 POOR**, by circling the number you feel most appropriate.

1. My appointment was scheduled in a reasonable amount of time and the person with whom I spoke with was courteous and helpful. **1 2 3 4 5**

2. I was seen within 15 minutes of my appointment and if not, the reason for the delay was explained to me. **1 2 3 4 5**

3. I found the waiting and treatment areas clean and well maintained. **1 2 3 4 5**

4. The services provided to me were delivered in a reasonable amount of time. **1 2 3 4 5**

5. Considering its limitations, I found the fit and function of my orthosis/prosthesis satisfactory. **1 2 3 4 5**

6. I have found that my orthosis/prosthesis is adequate for my needs. **1 2 3 4 5**

7. The appearance and workmanship of my orthosis/prosthesis is to my satisfaction. **1 2 3 4 5**

8. The Orthotist/Prosthetist who provided my service, was very knowledgeable and skillful. **1 2 3 4 5**

9. Overall I was satisfied with the quality of treatment I received. **1 2 3 4 5**

10. I received specific recommendations and/or instructions on proper care and use of my orthosis/prosthesis. **YES** **NO**

11. I would recommend Baker O & P to others requiring such services. **YES** **NO**

12. Please comment on your overall treatment and how we can improve our services. (Please use reverse side if more space is needed)

____

____

____

____

____

____

I would like to speak to someone from your office about the services provided.
(Please circle one) **YES** **NO**

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. 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.
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 calling beneficiaries in order to solicit new business.
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*

National Supplier Clearinghouse
P.O. Box 100142 • Columbia, South Carolina • 29202-3142 • (866) 238-9652
A CMS Contracted Intermediary and Carrier

Medicare Secondary Payer

Patient: ______________________________ **Date:** ___________________________________

Instructions: Please read and answer all questions in the left column. If the answer to any of these is "YES" fill out the information in the box on the right.

Are you or your spouse currently working for a company that provides you with group health insurance or retirement coverage that is primary over Medicare? – or – Does any member of your family have insurance for you through a group health plan: **YES:** _____________ **NO:** _____________	**Employer** ______________________________ **Insurance Co** ___________________________ **Name of insured** _________________________ **Policy #** ________________ **Group #** _____________
Are you a veteran filing for our services to VA for payment? **YES:** _____________ **NO:** ______________	**Social Security #** ____________________________ **VA "C" #** __________________________________
Is the need for our services the result of a motor vehicle accident or other accident outside your home? **YES:** ______________ **NO:** _______________	**Insurance Co** _________________________________ **Insured Party** ________________________________ **Claim #** ______________________________________ **Date of accident :** ___________________________ **Name / Address/ Phone # of Attorney:** ____ ____
Is the need for our services the result of an accident on the job? **YES:** ____________ **NO:** _________________	**Employer** ____________________________ **Insurance Co** _________________________ **Claim #** ______________________________ **Date of injury:** _________________________ **Name / Address of Attorney if in litigation:** ____ ____
Is insurance coverage provided under the United Mine Workers Black Lung Program? **YES:** _______________ **NO:** _______________	**Marital Status: Single** ______ **Married** ________ **Widowed** _____ **Divorced** _________ **Medicare #** ________________________________
Date of retirement: __________________________ **Spouse's date of retirement:** ________________	**Co-insurance information or Medicaid #** ____

Patient Signature : _____________________________________ **Date:** _______________________