aspire
PROSTHETICS & ORTHOTICS

PATIENT DEMOGRAPHIC INFORMATION

Today's Date: ________________ How did you hear about us? ________________________

Name:(First/Last) ___________________________Nickname: __________ Previous/Maiden Name: ______________

Male: __ Female: __ Date of Birth: ________Age: _____Social Security #: _____________ Email: ____________________

Single: _____ Married: _____ Divorced: _____ Widowed: _____

Mailing Address: ____________________________________ City: ___________________ State: _____ Zip: ________

Home: ____________________ Cell/Alternative: _____________________ Work Phone: ________________________

Which phone number is preferred? Home _____ Cell _____ Work ______ Language Preference: _____________

Employer: ____ Phone: ____________________________________

Employer Address: ___________________________________ City: ____________________ State: ____ Zip: ________

EMERGENCY CONTACT

Name: (First/Last) ____________________________ Relationship: __________________ Phone: ________________

Address: __________________________________City: ______________________ State: _____ Zip: ______________

Referring Physician: ______________________________ Phone Number:___________________________

Have you received a similar device in the past? Yes ____ No ___ If Yes, When:________________

Did your Insurance Company Cover that device? ____

Are you currently in a Medicare-covered bed at a skilled nursing facility? Yes____ No _____

Are you Diabetic: ☐ Yes ☐ No If yes, Diabetic Physician:____________________________ Phone # :_______________

Is your visit related to an injury? Yes_______ No_________ If Yes, : WORK_________ AUTO________ OTHER ______

Claim Adjuster:___________________________ Phone #:________________________ Date of Injury:____________

GUARANTOR/PERSON RESPONSIBLE FOR ACCOUNT

Please note, just because a spouse/parent carries the insurance plan, does not mean they are responsible for the balance due after insurance has processed.

☐ Same as Patient Information

Name:(First/Last) ____________________________________ Phone/Cell: ____________________________________

Relationship: ________________________ Social Security #: ___________________ Date of Birth: ________________

Employer: ____ Employer Phone: _______________________________

Address: ____________________________________ City: _______________________ State: ______Zip: __________

aspire
PROSTHETICS & ORTHOTICS

INSURANCE INFORMATION

We will request to scan/copy your ID and insurance card

Primary Insurance: ______________________________ Patient is Subscriber/Policy Holder: Y / N

Secondary Insurance: ______________________________ Patient is Subscriber/Policy Holder: Y / N

PATIENTS BILL OF RIGHT

As an individual receiving orthotic and prosthetic services from Aspire Prosthetics & Orthotics Inc., 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 Aspire Prosthetics & Orthotics Inc. 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 orthotic & prosthetic care 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 Orthotic & prosthetic service without fear of discrimination or reprisal.
8. To request and receive complete and up-to-date information relative to your 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 information 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.

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Aspire Prosthetics & Orthotics, Inc. or insurance company to release any information required to process my claims.

______________________________ ____________________ ____________________

Patient/Guardian Signature Relationship to Patient Date

aspire
PROSTHETICS & ORTHOTICS

PRODUCT WARRANTY

Aspire Prosthetics & Orthotics, Inc. warranties all "off-the-shelf" or prefabricated devices in accordance to the manufacturer's warranty. Please refer to the information included in the packaging literature/instructions.

Aspire Prosthetics & Orthotics, Inc. warranties all "custom" products and devices for Ninety (90) days from the date of delivery, providing the device or product is properly utilized and cared for in accordance with Aspire Prosthetics & Orthotics, Inc.'s use, care, and fitting instructions.

A product or device is NOT returnable if:

- The device/product has been personalized in any way.
- Alterations or adjustments made by anyone other than a practitioner of Aspire Prosthetics & Orthotics, Inc.
- The device/product has been excessively worn, used or soiled (at the discretion of Aspire Prosthetics & Orthotics Inc.).

Warranty is defined as replacement of the original product or device with the same or similar product/device, or repair of the existing product to "like-new" condition at no cost to the consumer or beneficiary.

PATIENT FREEDOM OF PROVIDER STATEMENT

Aspire Prosthetics & Orthotics, Inc. for an orthotic and/or Prosthetic device/product. I understand that "Aspire Prosthetics & Orthotics, Inc." is a separate organization from my referral source. I further understand that "Aspire Prosthetics & Orthotics, Inc." will bill me or my insurance company separately.

I understand my rights and responsibilities in this referral process and transaction. I also understand that I have the right to choose any qualified provider to provide me with an Orthotics/Prosthetics product/device. I have freely chosen Aspire Prosthetics & Orthotics, Inc. as my provider for this device/product.

Signature: ____ Date ________________

Print Name: ______________________________ Relationship to Patient ___________________

aspire
PROSTHETICS & ORTHOTICS

HIPAA INFORMATION AND CONSENT FORM

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. There are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

3. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

4. You agree to bring any concerns or complaints regarding privacy to the attention of the Executive Administrator [Angela Ansa, MPH] or clinician.

5. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

6. We agree to provide patients with access to their records in accordance with state and federal laws.

7. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

8. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, ____, **on** ______________________

Patient's Name Today's Date

do hereby consent and acknowledge my agreement to the terms set forth in this form and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

aspire
PROSTHETICS & ORTHOTICS

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.

______________________________ ____________________ ____________

Patient/Guardian Signature Relationship to Patient Date

aspire
PROSTHETICS & ORTHOTICS

PAYMENT POLICY

Aspire Prosthetics & Orthotics, Inc. understands the tremendous burden that can be created by healthcare expenses.

We will make every attempt to try to ease that burden. We ask that our patients understand the complex and costly process that is involved in fabricating customized prosthetic and orthotic devices.

We will be happy to assist you in working out a payment plan, helping to file insurance, or discussing possible alternative avenues of funding.

However, we cannot begin fabrication of a device until insurance verification is completed or other financial arrangements are made.

PRIVATE INSURANCE

Patients covered by a private insurance company are asked to pay their co-payment and the deductible in advance. Patients with two insurance companies are not required to make a down payment; however, the deductible amount may be required.

Aspire Prosthetics & Orthotics, Inc. agrees to bill most insurance carriers, if all necessary information is provided. Should your insurance not cover the services provided, the balance is your responsibility. If your insurance company has not paid your account within 60 days, the balance will be automatically transferred to your responsibility. A statement will be mailed to you and payment is expected upon receipt.

Your insurance policy is a contract between you and your insurance company. Coverage cannot be guaranteed. Estimates that we provide may be NON-COVERED services under the Medicare program and/or other medical insurance. In this instance, a statement will be mailed to you and payment is expected upon receipt. If you receive payment directly from your insurance carrier for services rendered to you by Aspire Prosthetics & Orthotics, Inc., you agree to forward that payment to us within five days of your receipt of the payment.

In the event that you are billed by Aspire Prosthetics & Orthotics, Inc. for services rendered and payment is not made, your account will be forwarded to our collection firm for further action. You will then be held responsible for all collection fees incurred including, but not limited to, lawsuit filing fees, service of process fees, attorney's fees, and all other legal fees and costs as a result of this action in addition to your outstanding balance with Aspire Prosthetics & Orthotics, Inc.

Usual and Customary Rates

It is our policy to charge our patients and their insurers in a fair and consistent manner. Our fees are set at usual and customary rates for this area.

Minor Patients

The adult accompanying a minor is responsible for payment. If the minor is unaccompanied by an adult, he/she must present payment at the time services are rendered or prior arrangements must be made.

aspire
PROSTHETICS & ORTHOTICS

MEDICARE AND MEDICAID

It is our policy, in the majority of cases, to accept direct Medicare and Medicaid assignments. In those cases in which we cannot accept assignment, we would ask to have 1/2 paid in advance and 1/2 upon delivery of the finished device. If special arrangements are needed, we will attempt to work out a plan for you before work is begun on the prosthesis or orthosis.

Returned Checks

Should you choose to make payment to Aspire Prosthetics & Orthotics, Inc. by check and it is returned, a fee of $25.00 will be charged to your account.

WORKER'S COMPENSATION AND VETERANS HEALTH ADMINISTRATION

Payment is not required for verifiable worker's compensation recipients. Veterans must present a C-card or appropriate authorization from the Veterans Health Administration.

DECLARATION OF WAIVER

I, ______________________________ have been informed of my financial responsibility for my device and service. I understand my insurance may cover for the device but I do not want Aspire Prosthetics and Orthotics to bill my insurance. I prefer to pay out of pocket.

FINANCING OPTIONS

CareCredit is a healthcare credit card designed for your health, and wellness needs. It's a way to pay for the costs of many treatments and procedures and allows you to make convenient monthly payments. CareCredit is accepted at over 200,000 providers nationwide for LASIK and Vision Care, Cosmetic and Dermatology Procedures, Dentistry, Veterinary, Hearing Care and other specialties. CareCredit is now also accepted at select retail locations.* For complete details of healthcare financing terms, please review the CareCredit account agreement within the application.

To learn more about Care Credit Patient Payment Plans visit: http://www.carecredit.com/iscc.html

Patient Name	
Patient Signature	
Date	

aspire
PROSTHETICS & ORTHOTICS

MEDICAL HISTORY FORM

Name: ______________________________________

Recent changes in weight? Y / N
Increase/Decrease
How much? ____________ lbs.

Date of Birth: ____________________

Height: ________ feet _______ inches

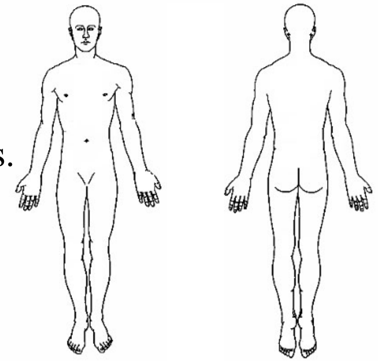
Weight: _____________________ lbs.

Shoe Size _________ width___________

Please check all that apply:

- ☐ Your injury is a result of an accident from employment.
- ☐ Your injury is a result of an auto accident.
- ☐ Your injury is a result of any other type of accident.

Mark the areas on your body where you feel the described sensations.
Use the appropriate symbol. Include all affected areas.



.... ____ …….	Dull Ache	--------- --------- ---------	Pins & Needles/ Tingling	///////// //////// ////////	Sharp Stabbing

Have you had any surgeries, or do you have any surgeries scheduled? Y / N

Injury/ Surgery Date: _____/_____/_____ Injury/ Surgery Date: _____/_____/_____

Please explain how the injury occurred ___________________________________

____

____

____

How is your general health?	Poor	Fair	Good	Excellent
Please circle your activity level:	Low	Medium	Active	Highly Active

Have you had or do you have any of the following:

__Heart Problems	__Hepatitis A or B	__Vision Problems	__Pacemaker/Defibrillator
__Hypertension	__Hepatitis C	__Parkinson Disease	__Seizure Disorder
__Vascular Disease	__HIV Positive	__Alzheimer Disease	__Hearing Loss
__Stroke	__Rheumatoid Arthritis	__Psychiatric Problem	__Currently Pregnant
__Diabetes	__Obesity	__Alcoholism	__MRSA
__Kidney Disease	__Osteoarthritis	__Known Allergies: (latex/ polypro/ plastic/ silicone)	
__Osteoporosis	__Pulmonary Disease	__ Amputation	