|  |
| --- |
| **Patient intake Form** |
| Patient Name: | DOB: |
| Street Address:  |
| City: | State  | Zip Code  |
| Mailing Address:  |
| Social Security # |
| Gender Female  Male  | Height | Weight  | Diabetic  Yes  NO  |
| Emergency Contact:  | Phone#  | Relationship:  |
| Primary Doctor  | Referring Doctor  |
| **Health Insurance** |
| Insurance Company: Medicaid  Medicare  |
| Policy Number | Group # |
| Policy Holder Name  | DOB:  |
| If the patient is not the policy holder, please indicate relationship: Spouse Child  |
| **Workers Compensation Patients Only (please fill out this section)** |
| Employer: |
| Employer Address:  |
| Claim Address:  |
| Adjuster:  | Date of Injury  |
| **Reason for Visit:**  |
| **Have you received similar device?  NO  Yes Date received \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_** |
| **Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**I the above Signed, hereby authorize Eddie Zepeda DBA PrimeCare Orthotics & Prosthetics to determine benefits and bill my insurance  |

**Acknowledgement of Receipt of HIPPA Privacy Notice**

I hereby certify that I have received a copy of Eddie Zepeda d/b/a PrimeCare Orthotics & Prosthetics' Notice of Privacy Practices. The Notice of Privacy Practices described the types of uses and disclosure of my protected health information which may occur during the course of treatment, determining benefits and applying for payment. The Notice of Privacy Practices also describes my rights and responsibilities as a patient, as well as the duties and standards of PrimeCare Orthotics & Prosthetics as a supplier.A copy of the Notice of Privacy Practices is posted at the front office reception area. PrimeCare Orthotics & Prosthetics reserves the right to revise the Notice of Privacy Practices. I may request a revised copy, to be sent via mail, by calling the office or asking for one at the time of *my* next appointment.

**Consent for Treatment**

The patient Intake packet Is to be completed by the patient or their legally authorized representative, parent or guardian: I hereby consent to treatment for myself or the patient for whom I am a legally authorized representative.I understand Eddie Zepeda d/b/a PrimeCare Orthotics & Prosthetics will share patient healthcare information according to federal and state law for treatment, payment and other related operations. I also understand the patient is responsible for all charges incurred, regardless of the patient's Insurance status.The patient agrees to pay for services as charges are incurred: I hereby authorize my Insurance provider(s) to pay Eddie Zepeda d/b/a PrimeCare Orthotics & Prosthetics for all services rendered.

**Product Warranty Information**

All prefabricated orthoses and/or prostheses provided by our company include a one (1) year manufacturer's warranty, unless otherwise advised. PrimeCare O&P will advise all Medicare beneficiaries of the warranty coverage and will honor all warranties under applicable law. I understand that the components of my custom device are fully guaranteed under normal use for 90 days and that PrimeCare Orthotics & Prosthetics will make any repairs to my device, as needed, and free of charge during the warranty period. I understand that this does not apply to charges in my physical weight, condition, nor any other physiological changes that may occur, or to any alterations made by anyone other than PrimeCare Orthotics &Prosthetics. In addition, PrimeCare Orthotics & Prosthetics will not be responsible for abuse, neglect, or normal wear and tear. I acknowledge that I have received care and use guidelines pertaining to this device (if applicable) as well as supplier standards. PrimeCare Orthotics & Prosthetics. All prescribed additions of componentry, straps, lifts, etc. will incur a charge. There will be a separate charge for adjustments and/or repairs made as a result of abuse or rough wear. Adjustments and/or repairs after six (6) months from the date of delivery *will* incur a minimal lab fee.

**Policy of Care and Payment**

Thank you for choosing PrimeCare Orthotics & Prosthetics, we are pleased to provide our services to you. Understandably, many of our patients like knowing what can be expected *regarding* their care and payment for services rendered. We hereby provide the following explanation of our Policy of Care and Payment: Insurance coverage for orthotics and/or prosthetics is a contract between you and your Insurance provider. As such, PrimeCare O&P will gladly submit a claim to your insurance provider on your behalf. However, you are personally responsible for knowing the policies of coverage and eligibility of your specific benefit plan. You will be responsible for any co-pays, deductibles, non-covered Items/services, and any portion of the charges not *covered* by your Insurance, Payment is due when the service is provided. You are ultimately responsible for the bill as well as assuring that payment Is made for all charges incurred. Eddie Zepeda d/b/a PrimeCare Orthotics & Prosthetics has no authority or control over the decisions of your Insurance provider. Please feel free to discuss all payment options with your practitioner. Thank you again, for choosing PrimeCare Orthotics & Prosthetics

**SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PRINTED NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

l, the undersigned have read and understood the above Information *I* acknowledge that I have received a copy of this form

**CONSENT FORM - RELEASE OF MEDICAL INFORMATION**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name of patient) authorize the release confidential healthcare information to PrimeCare Orthotics & Prosthetics for the purpose of treatment, payment, or healthcare operations of the company to whom this consent Is granted. I grant the authority to receive and disclose information regarding my health care needs.

**HEALTHCARE INFORMATION PERMITTED FOR RELEASE MAY INCLUDE BUT NOT LIMITED TO THE FOLLOWING:**

* Name, address, phone number Social Security Number
* Start of care date
* Diagnosis information / information about condition Insurance payer information

**CONDITIONS:**

1. The patient understands that his/her healthcare information may be disclosed to other healthcare providers for the purposes of treatment, payment or for healthcare operations without explicit consent, unless the patient has signed a notice of restriction of information.
2. The company reserves the right, in the future, to either honor or dismiss the patient's request to limit the use of the patient's healthcare information and to notify the patient, in writing, of such decision before the information is disclosed.
3. This consent form will be stored at the company for a period of six (6) years
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization n of this disclosure.

Signature of Patient or Legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICARE DMEPOS SUPPLIER STANDARDS**

Note: This is an abbreviated version of the supplier standards. Every Medicare OMEPOS 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 30days.
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.

1. 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.
2. 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.
3. 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.
4. **A** supplier must permit CMS or its agents to conduct on-site inspections to ascertain the supplier's compliance with these standards.
5. 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 poste d business hours is prohibited.
6. 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.
7. A supplier is prohibited from direct solicitation to Medicare beneficiaries. For complete details on this prohibition see 42 CFR§ 424.57 (c) (11).
8. 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.
9. A supplier must answer questions and respond to complaints of beneficiaries and maintain documentation of such contacts.
10. 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.
11. 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.
12. A supplier must disclose these standards to each beneficiary it supplies a Medicare-covered item.
13. A supplier must disclose any person having ownership, financial, or control interest in the supplier.
14. 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.
15. 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.
16. 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.
17. A supplier must agree to furnish CMS any information required by the Medicare statute and regulations.
18. 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 for in order for the supplier to receive payment for those specific products and services (except for certain exempt pharmaceuticals.)
19. All suppliers must notify their accreditation organization when a new DMEPOS location is opened.
20. All supplier locations, whether owned or subcontracted, must meet the DMEPOS quality standards and be separately accredited in order to bill Medicare.
21. All suppliers must disclose upon enrollment all products and services, Including the addition of new product lines for which they are seeking accreditation.
22. A supplier must meet the surety bond requirements specified in 42 CFR § 424.57 (d).
23. A supplier must obtain oxygen from a state-licensed oxygen supplier.
24. A supplier must maintain ordering and referring documentation consistent with provisions found in 42 CFR § 4 24.516(f).
25. A supplier is prohibited from sharing a practice location with other Medicare providers and suppliers.
26. 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.

OMEPOS suppliers have the option to disclose the following Statement to satisfy the requirement outlined in Supplier Standard 16 in lieu of providing a copy of the standards to the beneficiary. The products and/or services provided to you by (supplier legal business name or DBA) are subject to the supplier standards Contained in the Federal regulations shown at 42 Code of Federal Regulations Section 424.57(c). These standards concern business professional and operational matters (e.g. honoring warranties and hours of operation). The full text of these standards can be obtained at HTTP:/ /ecfr.gpoaccess.gov Upon request we will furnish you a written copy of the standard

**SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PRINTED NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

l, the undersigned have read and understood the above Information *I* acknowledge that I have received a copy of this form

**Patient Copy**

**Acknowledgement of Receipt of HIPPA Privacy Notice**

I hereby certify that I have received a copy of Eddie Zepeda d/b/a PrimeCare Orthotics & Prosthetics' Notice of Privacy Practices. The Notice of Privacy Practices described the types of uses and disclosure of my protected health information which may occur during treatment, determining benefits and applying for payment. The Notice of Privacy Practices also describes my rights and responsibilities as a patient, as well as the duties and standards of PrimeCare Orthotics & Prosthetics as a supplier. A copy of the Notice of Privacy Practices is posted at the front office reception area. PrimeCare Orthotics & Prosthetics reserves the right to revise the Notice of Privacy Practices. I may request a revised copy, to be sent via mail, by calling the office or asking for one at the time of *my* next appointment.

**Consent for Treatment:**

The patient Intake packet Is to be completed by the patient or their legally authorized representative, parent or guardian: I hereby consent to treatment for myself or the patient for whom I am a legally authorized representative. I understand Eddie Zepeda d/b/a PrimeCare Orthotics & Prosthetics will share patient healthcare information according to federal and state law for treatment, payment and other related operations. I also understand the patient is responsible for all charges incurred, regardless of the patient's Insurance status. The patient agrees to pay for services as charges are incurred: I hereby authorize my Insurance provider(s) to pay Eddie Zepeda d/b/a PrimeCare Orthotics & Prosthetics for all services rendered.

**Product Warranty Information:**

All prefabricated orthoses and/or prostheses provided by our company include a one (1) year manufacturer's warranty, unless otherwise advised. PrimeCare O&P will advise all Medicare beneficiaries of the warranty coverage and will honor all warranties under applicable law. I understand that the components of my custom device are fully guaranteed under normal use for 90 days and that PrimeCare Orthotics & Prosthetics will make any repairs to my device, as needed, and free of charge during the warranty period. I understand that this does not apply to charges in my physical weight, condition, nor any other physiological changes that may occur, or to any alterations made by anyone other than PrimeCare Orthotics **&**Prosthetics. In addition, PrimeCare Orthotics & Prosthetics will not be responsible for abuse, neglect, or normal wear and tear. I acknowledge that I have received care and use guidelines pertaining to this device (if applicable) as well as supplier standards. PrimeCare Orthotics & Prosthetics. All prescribed additions of componentry, straps, lifts, etc. will incur a charge. There will be a separate charge for adjustments and/or repairs made as a result of abuse or rough wear. Adjustments and/or repairs after six (6) months from the date of delivery *will* incur a minimal lab fee.

**Policy of Care and Payment**:

Thank you for choosing PrimeCare Orthotics & Prosthetics, we are pleased to provide our services to you. Understandably, many of our patients like knowing what can be expected *regarding* their care and payment for services rendered. We hereby provide the following explanation of our Policy of Care and Payment: Insurance coverage for orthotics and/or prosthetics is a contract between you and your Insurance provider. As such, PrimeCare O&P will gladly submit a claim to your insurance provider on your behalf. However, you are personally responsible for knowing the policies of coverage and eligibility of your specific benefit plan. You will be responsible for any co-pays, deductibles, non-covered Items/services, and any portion of the charges not *covered* by your Insurance, Payment is due when the service is provided. You are ultimately responsible for the bill as well as assuring that payment Is made for all charges incurred. Eddie Zepeda d/b/a PrimeCare Orthotics & Prosthetics has no authority or control over the decisions of your Insurance provider. Please feel free to discuss all payment options with your practitioner. Thank you again, for choosing PrimeCare Orthotics & Prosthetics

**Compliance to Laws and Commitment to Quality**

PrimeCare Orthotics & Prosthetics is committed to complying with all federal and state regulations. If you have any questions or concerns regarding any of our activities, please contact us at 575-522-227. If after speaking with us, you still feel that we are not in compliance with regulations or that fraud has occurred, you can call the Medicare Fraud Hotline at 1800-447-8477

If you feel you have complaints about the quality of products or services that you have been unable to resolve with us you may contact our accrediting agency, Board of Certification/ Accreditation International at 1877-776-2200

**Patient Complaint Policy**

All of our customers are very important to us, so that we can resolve any problems that arise in a rapid and effective manner, we have developed the following methods for you to let us know if you have a complaint

* When you have concern you can speak to the person from our company that has provided the product and/or service to you at that time
* You can call our office at 575-523-2273 and speak to a customer service representative or manager.
* You may also contact us in writing at the following address

**PrimeCare Orthotics and Prosthetics**

**1401 S. Don Roser Ste E2**

**Las Cruces, NM 88011**

All complaints will be documented immediately and investigated within 24 hours and will receive a prompt verbal/written response to your complaint within 14 days of issuing the complaint as required by the centers for Medicare& Medicaid