WESTCOAST

Restoring bodies. Rebuilding lives.

PATIENT INTAKE FORM

PATIENT INFORMATION

Date _____

Is your visit with us related to a work comp injury? ☐ YES ☐ NO *(If YES, complete last page)*

Patient Name: First: _____ Middle Initial: _____ Last: _____

Social Security #: _____ - _____ - _____ DOB: _____- _____ - _____ ☐ Male ☐ Female

☐ Single ☐ Married ☐ Other

Phone: _____ Work: _____ Cell: _____

☐ *By checking this box, you authorize Westcoast Brace & Limb to leave detailed phone messages for you, which may include private healthcare information.*

Email: _____

Address: _____ City: _____ State: _____ Zip: _____

☐ *By checking this box, you authorize Westcoast Brace & Limb to utilize email as a form of communication with you. Our communications only include information regarding your treatment plan, updates, and our services. Your social security number will never be included in an email communicate from us.*

RESPONSIBLE PARTY

(Check one): ☐ The responsible party listed above ☐ Is different than above

Full Name: _____ Relationship: ☐ Self ☐ Spouse ☐ Dependent ☐ Other

Social Security #: _____ - _____ - _____ DOB: _____- _____ - _____

Phone: _____ Work: _____ Cell: _____

EMERGENCY CONTACT

Full Name _____ Phone _____

MEDICAL PROFESSIONALS INVOLVED IN YOUR CARE

☐ Prescribing Physician: _____ Phone: _____

☐ Primary Care Physician: _____ Phone: _____

☐ Other_____ Phone: _____

OTHER HEALTH CONDITIONS (Please check all that apply):

☐ Arthritis
☐ Osteoporosis
☐ Fibromyalgia
☐ Joint Pain
☐ Muscle Pain
☐ Vascular Disease
☐ Previous Heart Attack
☐ Gout
☐ Stroke
☐ Chronic Pain
☐ Chronic Fatigue Syndrome
☐ Autoimmune Disease
☐ Rheumatoid Arthritis
☐ Obesity
☐ Type 1 Diabetes
☐ Type 2 Diabetes
☐ Wound Heal Delay
☐ Respiratory Disease
☐ Depression
☐ Anxiety
☐ Memory Loss
☐ Cancer
☐ Parkinson's Disease
☐ Multiple Sclerosis
☐ Seizures
☐ Cerebral Palsy
☐ Post-Polio
☐ HIV/AIDS
☐ MRSA
☐ Pregnancy
☐ Previous Surgery:

_____

WESTCOAST

Restoring bodies. Rebuilding lives.

PATIENT INTAKE FORM

INSURANCE INFORMATION

Please provide a copy of your photo ID, all insurance cards, and any prescriptions that you have.

Primary Insurance: _____ Policy ID: _____ Group: _____

If the policy holder is someone other than the patient: ☐ Spouse ☐ Dependent ☐ Not related

Policy Holder Name: _____

DOB: _____ - _____ - _____ Social Security: _____ - _____ - _____

Secondary Insurance: _____ Policy ID: _____ Group: _____

If the policy holder is someone other than the patient: ☐ Spouse ☐ Dependent ☐ Not related

Policy Holder Name: _____

DOB: _____ - _____ - _____ Social Security: _____ - _____ - _____

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I, _____ give permission to Westcoast Brace & Limb to release any information, verbally or written, on my behalf to the following persons. Please note that in order for WCBL to communicate to anyone other than the patient/guardian, that individual's name must be listed below.

Name:_____ Phone: _____

Relationship to Patient _____

CLINICAL PHOTOGRAPH RELEASE

I understand that Westcoast Brace & Limb may obtain a photograph of me for clinical purposes. This photograph of me will remain in my records and may be forwarded to my treating medical professional(s) (physician, nurse, therapist, etc...) for clinical purposes.

Patient/Guardian Signature: _____ Date: _____

How did you hear about Westcoast Brace & Limb? (Check all that apply)

☐ Medical Professional ☐ Hospital Visit ☐ Insurance ☐ Internet ☐ Print Ad

☐ Television ☐ Another WCBL Patient ☐ Military Base/MAFB ☐ WCBL Mailer/Postcard

WESTCOAST

Restoring bodies. Rebuilding lives.

PATIENT INTAKE FORM

PATIENT CONSENT & AUTHORIZATION FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I acknowledge receipt of notice of privacy practices and authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment of other healthcare providers/vendors involved in my treatment)
- Obtaining payment from third party payers
- The normal healthcare operations of your practice

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that I may contact you to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree with these restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use of disclosure that occurred prior to the day I revoked this consent is not affected.

In the event this practice changes hands, I also give you permission to transfer my records.

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but could not obtain because:

☐ Individual refused to sign

☐ Communication barrier prohibited

☐ An emergency situation prevented obtaining acknowledgement

☐ Other _____

WESTCOAST

Restoring bodies. Rebuilding lives.

PATIENT INTAKE FORM

BENEFITS, MEDICAL INFORMATION RELEASE AUTHORIZATION & ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

I request my insurance benefits, if any, be paid directly to the provider. I authorize the release of any information necessary to provide services or process claims. As the responsible party, I understand that I am personally responsible for the entire amount of my claim and that insurance benefits may be limited or non-existent. I agree to notify Westcoast Brace & Limb of any change in insurance coverage of status.

LIFETIME MEDICARE B SIGNATURE & ASSIGNMENT OF/AND AUTHORIZATION TO PAY MEDICAL EXPENSE BENEFITS

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration, to its' intermediaries or carriers or billing agent of designated carrier, any information needed to this or a related claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the party who accepts assignment.

If policy specifically prohibits assignment, I request a check be made payable to BOTH SUBSCRIBER AND ABOVE COMPANY and sent directly to the COMPANY. NOTE: Payment by an obligor to a person other than the assignee after notification of assignment may result in liability to the obligor to repay the amount paid.

SECONDARY INSURANCE AUTHORIZATION & ASSIGNMENT

I authorize payment of medical benefits to the party who accepts assignment.

RESPONSIBILITY

I understand that the entire amount of the fees for your services and/or Orthotic and Prosthetic devices is my personal responsibility even though this may or may not be covered by insurance. If you bill the insurance company directly, I understand that I am to pay my portion of the bill when your service is rendered. I further agree to personally pay within thirty (30) days any portion of the bill that is outstanding.

In the event this bill is turned over to a third party for collection, I agree to pay all reasonable collection fees including attorney and Court cost, plus 1.5 percent monthly charge on the outstanding balance.

Patient Signature: _____ Date: _____

WESTCOAST

Restoring bodies. Rebuilding lives.

PATIENT INTAKE FORM

DMEPOS SUPPLIES 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 and cannot contr act with an individual or entity to provide licensed services.
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. This standard requires that the location is 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 reco rds.
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, 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 pla ce 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 contacting a Medicare beneficiary based on a physician's oral order unless an exception applies.
12. A supplier is responsible for delivery and must instruct beneficiaries on use of Medicare covered items, and maintain proof o f 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, Med icare- 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 (inappropr iate 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 stand ards. 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 i n 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
27. A supplier must obtain oxygen from a state- licensed oxygen supplier.
28. A supplier must maintain ordering and referring documentation consistent with provisions found in 42 C.F.R. 424.516(f).
29. DMEPOS suppliers are prohibited from sharing a practice location with certain other Medicare providers and suppliers.
30. DMEPOS suppliers must remain open to the public for a minimum of 30 hours per week with certain exceptions.

I acknowledge receipt of a copy of the Medicare Supplier Standards from Westcoast Brace & Limb.

Patient Signature: _____ Date: _____

WESTCOAST

Restoring bodies. Rebuilding lives.

PATIENT INTAKE FORM

WORK COMPENSATION INFORMATION/THIRD PARTY LIABILITY

If your care involves a Work Compensation claim or third party liability, please complete the following information below:

Date: _____ Patient Name:_____

Employer (at time of injury): _____ Phone:_____

Date of Injury: _____ - _____ - _____ State Where Injury Occurred: _____

Insurance Carrier Name: _____ Claim #: _____

Claims Adjuster:_____ Phone :_____

AUTO ACCIDENT / THIRD PARTY LIABILITY

☐ Please check here if your injury was due to an auto accident

☐ Please check here if your injury was due to third party liability (someone else is liable for your injury)

☐ Please check here if you have an attorney
Attorney Name: _____ Phone: _____

☐ Please check here if you have filed a lawsuit related to your injury

VERIFICATION OF INFORMATION ACCURACY

I verify that, to the best of my knowledge, the information I have provided in this 4 page form is accurate.

Patient Signature: _____ Date: _____