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PATIENT INFORMATION FORM

Please Print all Information

Section 1 – Patient Information							
Patient Name:		SSN:		Date of Birth:			
Home Address:		City:		State:		Zip:	
Home Tel #:		Work Tel #:		Mobile #:			
Sex:	Male/Female	Martial Status:	Single / Married / Other	Height:		Weight:	
Patient's Employer:							
Employer's Address:		City:		State:		Zip:	
Spouse's Name:		Work Tel #:		SSN:			
Email Address:							
Section 2 – Parent / Guardian / Responsible Party							
Name (Last, First, MI):		SSN:		Date of Birth:			
Relationship to Patient:	Spouse / Parent / Guardian / Other (Explain)						
Employer:		Tel #:					
Employer's Address:		City:		State:		Zip:	
Section 3 – Emergency Contact							
Name (Last. First, MI):							
Work Tel #:		Home Tel #:		Relationship:			
Section 4 – Medical Information							
Diagnosis:		Date of injury:					
How/Where did the injury occur:							
Primary Care Physician:		Tel #:					
Referring Physician:		Tel #:					
Are You Diabetic?	Y / N	Physician Managing Diabetes:		Tel #:			
If Amputation, Amputation Date:		Level of Amputation:		Amputation Side:	R L B|L		
Section 5 - Insurance Information							
Is this Worker's Comp Claim?	Y / N		(If Yes, please complete WORKER'S COMP form)				
Is this due to an Auto/Home accident?	Y / N	Date of Injury:		State that Accident Occurred In:			
Auto/Home Insurance Carrier:		Policy #:					
Contact Person:		Tel #:					
Primary Insurance:				**Secondary Insurance:**			
Policyholder:				Policyholder:			
Policyholder DOB:				Policyholder DOB:			
Policyholder SSN:				Policyholder SSN:			
Group #:		ID #:		Group #:		ID #:	
Case Mgr:		Tel #:		Case Mgr:		Tel #:	
Patient's Relationship to Policyholder:				Patient's Relationship to Policyholder:			

I certify that all information provided above is true, accurate, and complete.

Signature of Patient | Date | Signature of Parent or Guardian

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PATIENT ACKNOWLEDGMENT FORM

As part of the admission process, you will be receiving information on several policies and procedures that we implemented to ensure your treatment while in our care is of the highest quality. This acknowledgment indicates your receipt of such information at the time of your initial registration or patient contact.

Provider Privacy Practices & Patient Bill of Rights - Provider Privacy Practices discloses how medical information may be used and disclosed and how you can get access to this information. Patient Bill of Rights, details your rights as a patient.

Warranty Policy - Describes DISTRICT AMPUTEE CARE CENTER, LLC's policies with respect to warranty period and repairs/adjustments.

Patient Financial & Office Policies Agreement - This explains DISTRICT AMPUTEE CARE CENTER, LLC's policies with respect to billing your insurance and collecting applicable co-pays, deductibles, finance charges, missed appointments, and collection accounts,

Urgent Care - Informs you of our urgent care procedures.

Patient Complaint Process - This notifies you of our complaint and resolution process.

Medicare Supplier Standards - Outlines standards that are to be maintained by DISTRICT AMPUTEE CARE CENTER, LLC as a Medicare provider.

Consent to Treat - I hereby authorize DISTRICT AMPUTEE CARE CENTER, LLC to provide requested orthotic and/or prosthetic services.

Have you received a like or similar device within the last 5 years from either DISTRICT AMPUTEE CARE CENTER, LLC or any other provider?

Are you currently residing in a nursing home?

Do you have surgery scheduled to treat the same condition for which this device will be utilized?

Assignment of Benefits & Communication - | hereby authorize DISTRICT AMPUTEE CARE CENTER, LLC to release necessary medical information to my insurance carrier(s) to process my medical claim. I also authorize my insurance carrier to pay benefits directly to DISTRICT AMPUTEE CARE CENTER, LLC. I authorize DISTRICT AMPUTEE CARE CENTER, LLC to leave messages via phone and email. I authorize DISTRICT AMPUTEE CARE CENTER, LLC to collect information from my physicians in order to receive information for payment of their services for my device.

I request that payment of authorized Medicare and Insurance benefits be made to DISTRICT AMPUTEE CARE CENTER, LLC on my behalf for any services furnished to me by DISTRICT AMPUTEE CARE CENTER, LLC. I authorize anyone who holds medical or other information to the Centers for Medicare and Medicaid Services and its agents in order to determine these benefits for related services.

I, the undersigned, have received, read and understand these policies and agreements and hereby consent to the above as indicated by my initials. I also attest that the above questions have been answered truthfully to the best of my knowledge.

Signature of Responsible Party: Date:

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WARRANTY POLICY

The warranty period for custom prostheses is three months for workmanship and materials. Although District Amputee Care Center, LLC can not be responsible for physiological or anatomical changes in a patient's medical condition, we will attempt to maintain proper fit during this period. Additions of components, straps, lifts, etc. prescribed by a physician will incur a charge. There will be a separate charge for adjustments or repairs that are made as a result of abuse or tough wear, as may occur from sporting, vocational, or unusual activities.

Since prostheses are prescribed at the direction of a physician and are custom fabricated for the anatomy and medical condition of each individual, they cannot be returned for credit or refund. Prescribed “off the shelf" items cannot be returned for hygienic reasons.

Please communicate any problems or discomfort you are experiencing to your practitioner immediately to allow us to resolve these problems as efficiently and quickly as possible. We will make every attempt to meet your needs. Thank you.

PATIENT FINANCIAL & OFFICE POLICIES AGREEMENT

To prevent any misunderstanding about medical insurance, we wish to point out that (1) Payment for all medical services furnished are the responsibility of the patient; (2) Deductibles and/or co-payments are due at the time services are rendered; (3) Fifty percent (50 %) of the balance for non-covered custom-made devices is due at the time of cast and measure, with the balance due at the time of delivery; (4) DISTRICT AMPUTEE CARE CENTER, LLC will bill your insurance company as a courtesy to you, however, DISTRICT AMPUTEE CARE CENTER, LLC is not responsible for non-payment from the insurance company; (5) If, due to unforeseen circumstances, additional procedures and/or treatments are necessary beyond what has been previously approved, patients must make arrangements for payment, (6) Patients are expected to keep their accounts current while waiting for their insurance company to remit payment.

Your insurance coverage is a contract between you and your insurance company to help you meet medical expense. District Amputee Care is not a party to that contract. Because benefits can vary greatly, it is not possible for DISTRICT AMPUTEE CARE CENTER, LLC to provide services on the basis that your insurance company will pay all charges.

DISTRICT AMPUTEE CARE CENTER, LLC can in no way guarantee coverage. Benefits are determined by your insurance at the time your claim is processed. All benefit calculations are only an estimate, based on information obtained from your insurance company. The actual final Total Patient's Responsibility may be different than what was previously calculated by DISTRICT AMPUTEE CARE CENTER, LLC.

Payments may be made by check, money order, Visa or MasterCard. A $35.00 fee will be assessed for any check returned for any reason.

Medicare Billing: We will bill your Medicare carrier for covered services. At the time services are provided, we require a payment for your portion of the charges plus any deductible that remains.

Medicaid Billing: Medicaid claims may require a prior authorization before any services can be provided.

Auto Insurance: For all insurance claims we require payment at the time services are provided.

Billing Procedure: We mail monthly statements at the end of each month. Payment is due upon receipt.

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PATIENT FINANCIAL & OFFICE POLICIES AGREEMENT

Finance Charges: A finance charge of 18% will be applied to any unpaid balance that exists for more than 30 days.

Collection Accounts: Only utilized as a last resort, collection procedures shall be implemented for past due accounts which will include a 33.33% collection fee. Please discuss your balance and payment options with our financial coordinator. If it becomes necessary to forward your account to a collection agency, you will be responsible for all accrued applicable interest, collection fees, and possible attorney fees.

Missed Appointments: In an effort to best accommodate all of our patients, all cancellations and rescheduling of appointments must be made 24 hours in advance, and only during business hours. In the event of a late cancellation (less than 24 business hours notice) DISTRICT AMPUTEE CARE CENTER, LLC will charge a $25.00 fee. This insure that you will receive 100% of the prosthetist's time and attention.

URGENT CARE

DISTRICT AMPUTEE CARE CENTER, LLC is aware of the importance of our patients wearing of the prosthesis that has been provided. In the event that a prosthesis is in the need of immediate repair, it will receive the highest priority and every effort will be made to repair or replace the device as soon as possible. In the event this an urgent need arises concerning your prosthesis, please call our office device, and A DISTRICT AMPUTEE CARE CENTER, LLc representative will return your call as soon as possible, during normal business hours.

PATIENT COMPLAINT PROCESS

We are committed to ensuring you are completely satisfied with the services and care you receive at DISTRICT AMPUTEE CARE CENTER, LLC. However, if for any reason you wish to file a complaint, any staff member can assist you in this confidential matter. You will be asked to complete a "Patient Complaint Form" to assist us in understanding your complaint or concern fully. Once the form is received, a company representative will investigate the complaint thoroughly and take the necessary actions to satisfy your complaint. You will be notified of the receipt and actions taken, as appropriate, within 5 business days of receipt of your Patient Complaint Form.

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PATIENT BILL OF RIGHTS

1. Every patient shall have the right to considerate and respectful care.

2. Every patient can reasonably expect complete and current information concerning his/her diagnosis, treatment and prognosis in terms he/she can understand. When it is not medically advisable to give the information to the patient, it may be made available to the appropriate person on his/her behalf.

3. Every patient shall have the right to know by name and specialty, if any, the practitioner responsible for coordination of his/her care.

4. Every patient shall have the right to every consideration of his/her privacy and individuality as it relates to his/her social, religious and psychological well being.

5. Every patient shall have the right to respectfulness and privacy as it relates to his/her medical care program. Case discussion, consultation, examination, and treatment are confidential and should be conducted discreetly.

6. Every patient shall have the right to expect DISTRICT AMPUTEE CARE, LLC to make reasonable response to his/her requests.

7. Every patient shall have the right to obtain information on the relationship of DISTRICT AMPUTEE CARE CENTER, LLC to other health care and related institutions insofar as his/her care is concerned.

8. Every patient shall have the right to expect reasonable continuity of care. This shall include but not be limited to what appointment times and practitioners are available.

9. Every patient shall be fully informed prior to treatment of the services available in DISTRICT AMPUTEE CARE CENTER, LLC and of related charges, including any charges for services not covered under Medicare or Medicaid.

10. Every Patient shall have the opportunity to participate in the planning of his/her medical treatment and to refuse to participate in experimental research.

11. Every patient shall be assured confidential treatment of his/her personal and records, and may approve or refuse their release to any individual outside DISTRICT AMPUTEE CARE CENTER, LLC except as otherwise provided by law or as stated in DISTRICT AMPUTEE CARE CENTER, LLC Notice of Privacy Practices.

12. Every patient shall be fully informed, prior to treatment of the rights and responsibilities set forth in this section and of all rules governing patient conduct and responsibilities.

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PHOTOGRAPHIC CONSENT FORM

Patient: Date:

I (or)

Authorize and ratify any photographing of myself (or of the above named patient) by District Amputee Care Center, LLC in connection with diagnosis and treatment as determined by the attending physicians and any consultants, and for scientific and educational purposes. (Photographs may be used for visual presentations in physician, medical student, and ancillary health educational training programs, may be incorporated with the patient's medical record for documentation of care, and may be used in conjunction with articles in medical or scientific publications.) My name (or the name of the aforementioned patient) shall not be used to identify said photographs, outside of the medical record.

I hereby certify that I have read and fully understand the above provisions.

Witness Signature of Patient Date

If patient is a minor or is able to consent, complete the following:

The patient is unable to consent because (a) the patient is a minor years id age or (b) other reason

The undersigned (acting on behalf of all parents and guardians), certifies that the undersigned is a parent or legal guardian and has full and complete authority from said patient’s other parent or legal guardian(s) to give the above consent and make the representation hereunder on their behalf.

Witness Signature of Parent of Guardian Date

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