ALLTECH
ORTHOTICS & PROSTHETICS
Toll Free: 888-897-3231
www.AlltechOP.com

DATE: _____ Mr. ☐ Mrs. ☐ Miss ☐ Male or Female

Patient Name _____ Date of Birth _____
Last Name First Name M.I.

Home Address _____
City State Zip

Phone _____
Home Work Cell

Email Address: _____

Social Security #: _____ Drivers License: _____

Marital Status: _____ Occupation: _____

Responsible party: _____ SS#: _____

Employer: _____ Employer Phone: _____

Employer Address: _____
City State Zip

Emergency Contact: _____ Phone: _____

Referring Physician: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

_____

Type of Insurance Coverage (Please Circle) Commercial ☐ Medicare ☐ HMO ☐ PPO ☐ Work Comp ☐ Liability ☐ None ☐

Primary Insurance Carrier: _____
Phone

Policy#/ID: _____ Group#: _____

Policy Holder_____ SS#_____ D.O.B.___/___/_____ Relationship_____

Secondary Insurance Carrier: _____
Phone

Policy#/ID: _____ Group#: _____

Policy Holder_____ SS#_____ D.O.B.___/___/_____ Relationship_____

_____

Is injury related to: Work ☐ Auto ☐ Other Accident ☐ Non Accident Date of Injury: _____

Work Comp/Auto: Claim # _____ Adjuster/Case Manager: _____

Carrier Name & Address: _____

Phone: _____ Fax: _____

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RELEASE OF INFORMATION
CONSENT FOR TREATMENT
PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

Patient Name: _____ **Date of Birth**: _____

CONSENT FOR TREATMENT: I, the undersigned, do voluntarily agree and give my consent to Alltech O&P Services, LLC to furnish medical care and treatment considered necessary and proper for the condition for which I have been referred. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of my treatment rendered. I understand that a minor child under the age of 18 must be accompanied by an adult who may authorize care.

Please Initial _____

RELEASE OF INFORMATION: I hereby authorize Alltech O&P Services, LLC to release any information acquired in the course of my treatment to process insurance claims for services rendered. I appoint Alltech O&P Services, LLC to act as my authorized representative in requesting an appeal from my insurance plan regarding its denial of services or payment. I hereby authorize release of any kind and all medical information to previous and future physicians or other healthcare individuals involved in my care. I hereby authorize any physician, hospital, or medical care facility to provide any information on my medical history and treatment to Alltech O&P Services, LLC. I hereby authorize photocopies of this form to be as valid as the original.

Please Initial _____

FINANCIAL RESPONSIBILITY: I understand that payment is due at the time services are rendered. As a courtesy, most insurance claims will be filed on my behalf by Alltech O&P Services, LLC. I am aware that my insurance company, worker's compensation carrier, employer, or other agent may not pay for my treatment. In the case of default of payment for services, I hereby agree to pay any and all collection fees. A billing fee may be charged to cover monthly statements, and I acknowledge that this is my sole responsibility. I understand and agree it is my responsibility, and not the responsibility of Alltech O&P Services, LLC to know if my insurance will pay for medical services, and if the practitioner I am seeing or the facility I use is a contracted in-network provider recognized by my insurance company or plan. If they are not recognized by my insurance company or plan, it may result in claims being denied or higher out of pocket expenses. I understand and agree it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out-of-network amount, usual and customary limit, or any other type of benefit limitation for the services I will receive. I agree to be financially responsible for any charges not paid for by my insurance carrier.

Please Initial _____

RETURNED CHECKS: I understand that all Insufficient and Closed Account checks will be prosecuted to the fullest extent of the law. All returned checks are subject to a collection fee. A valid credit card will be required to write checks. I understand if a check is returned by the bank unpaid, I will no longer be able to write a check and will pay by cash or credit card.

Please Initial _____

FORMS: There will be a $20.00 charge for each disability form completed by this office. This fee is to be paid in cash at the time of the request. The patient portion of the form must be completed and signed. All disability forms are given to the practitioner for review and signatures. Please allow 5 days for complete processing of your form. A valid HIPPA authorization to release protected health information is required to release.

Please Initial _____

ASSIGNMENT OF BENEFITS: I hereby authorize Alltech O&P Services, LLC to receive payment directly from my insurance carrier for any services payable under the terms of my insurance coverage. I hereby guarantee payment in full for all services rendered to myself or the above named patient upon receipt of billing and/or verbal notification from Alltech O&P Services, LLC

Please Initial _____

PHOTO/VIDEO PHOTOGRAGHY CONSENT: I hereby authorize Alltech O&P Services, LLC to take photos or video coverage of myself and the device that is being delivered to me from Alltech O&P Services, LLC. I understand that Alltech O&P Services, LLC will only uses these photographs or video coverage in conjunction with my insurance company or another medical professional in direct relation to my treatment. If Alltech requests to use my photographs for any other specific purpose I will sign another release for indication specific use and disclosure.

Please initial _____

Date: _____ Signature: _____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Alltech O&P Services, LLC may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to their Notice of Patient Information Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Patient Information Practices prior to signing this consent. Alltech O&P Services, LLC reserves the right to revise its Notice of Patient Information Practices at anytime. A revised Notice of Patient Information Practices may be obtained by requesting one from any office personnel.

With my consent, Alltech O&P Services, LLC may call my home, or other designated location, and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including test results among others.

With my consent, Alltech O&P Services, LLC may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request Alltech O&P Services, LLC restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Alltech O&P Services, LLC use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my consent. If I do not sign this consent, Alltech O&P Services, LLC may decline to provide treatment to me.

I authorize Alltech O&P Services, LLC to discuss or release information about my care, treatment, or diagnosis to the following persons:

Name:	Relationship:	Phone:
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ _____

Signature of Patient or Legal Guardian | Date

_____ _____

Printed Name of Patient | Witness

PATIENT / CLIENT BILL OF RIGHTS

As an individual receiving a device or consultation from Alltech, LLC let it be known and understood that you have the following rights:

1. To select those who provide you with orthotic and/or prosthetic services.
2. To be provided with legitimate identification by any person or persons who provides service to you from our company.
3. To receive the appropriate or prescribed service in a professional manner without discrimination relative to your age, sex, race, religion, ethnic origin, or physical or mental handicap.
4. To be dealt with and treated with friendliness, courtesy and respect by all staff.
5. To assist in the development and planning of your healthcare program.
6. To be provided adequate information from which you can give your informed consent for the device you seek evaluation for.
7. To express concern or grievances or recommend modifications with your practitioner for your prescribed device.
8. To request and receive complete and up to date information relative to your condition, treatment, or risk of treatment.
9. To refuse treatment if you are not satisfied with any aspect of care provided by our company.
10. To request and receive data regarding a fair estimate of financial responsibility.
11. To request a copy of your medical records.

PATIENT RESPONSIBILITY

1. To provide Alltech, LLC with your current verifiable photo identification and insurance coverage.
2. To provide us with your current address and phone numbers and advise of any new information as soon as it changes.
3. To notify Alltech, LLC of all your other medical providers in relation to your care being provided.
4. To provide us with honest and current feedback in regards to the fit and functionality of the device you receive.
5. To attend and return to our office as scheduled for the proper follow up in relation to your device.
6. To notify Alltech, LLC of the all previous devices you have been given or used.

RETURN /REFUND POLICY

Here at Alltech, LLC we will make all reasonable attempts to assure a proper fit and functionality of your device. Due to the single use nature of these prescribed devices product returns are not accepted for any custom made items. Certain items may be eligible for exchange if they are returned within the initial warranty period of 90 days and as long as the item can be returned to the manufacturer for credit. Generally these items must be in the original package and unworn. Please note we will not accept exchanges if you as a patient have not adhered to your responsibility and kept all scheduled follow up appointments.

I HAVE READ AND UNDERSTAND ALL THE ABOVE POLICIES

PATIENT SIGNATURE _____ **DATE**_____

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HIPPA DOCUMENTS AND SUPPLIER STANDARDS RECEIPT

I, _____, have received the following document(s) on _____.
(Name Of Patient) (Date)

DOCUMENT NAME	DESCRIPTION
HIPPA Notice.doc	HIPPA NOTICE
Medicare+DMEPOS+CMS Supplier Standard.pdf	CMS SUPPLIER STANDARD

_____ _____
(**PATIENT NAME** or **GUARDIAN**) (**DATE**)

Notice of Confidentiality: This document contains unconditionally private medical records. Any improper use of this information contained herin constitutes a breach of patient medical confidentiality.

CMS Medicare durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Supplier Standards

Note: This list 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 contract 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, with visible signage. 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 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 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*
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.

Patient Copy to Keep

NOTICE OF PATIENT INFORMATION PRACTICES

This notice describes how medical information about you may be used or disclosed and how you can get access to information. Please review carefully.

ALLTECH O&P SERVICES, LLC LEGAL DUTY

Alltech O&P Services, LLC is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Alltech O&P Services, LLC uses your personal health information primarily for treatment: obtaining pay for treatment: conducting internal administrative activities and evaluation of the quality of care that we provide. For example, Alltech O&P Services, LLC may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Alltech O&P Services, LLC may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information whenever required by law.

In any other situation, Alltech O&P Services' policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason you may later revoke that authorization to stop further disclosures at any time.

Alltech O&P Services, LLC may change its policy at any time. When changes are made, a new notice of information practices will be posted in the waiting room and will be provided to you on your next visit. You may also request an updated copy of our notice of information practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. Alltech O&P Services, LLC will consider all such requests on a case-by-case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that Alltech O&P Services, LLC may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on Alltech O&P Services, LLC health information practices or if you have a complaint, please contact the following person:

Cheryl DeLeon, Office Manager
Email: cheryldeleontx@aol.com
2781 S.W. Wilshire Blvd, Texas 76028 817-484-9699 phone 817-484-9877 fax

Patient Copy to Keep