Patient Intake Form

RETURN TO OFFICE

PATIENT INFORMATION

Last Name:	First Name:	Middle Name:	Suffix:

SSN:	DOB:	Gender:	Height:	Weight:

Mailing Address:	Preferred Language:
Physical Address (if different):	

City:	State:	Zip Code:	County:

Primary Phone:	☐ Home	☐ Work	☐ Mobile	Okay to text? ☐ Yes ☐ No
Secondary Phone:	☐ Home	☐ Work	☐ Mobile	Okay to text? ☐ Yes ☐ No

E-mail:	☐ I permit Tegerstrand Orthotics & Prosthetics to contact me through the e-mail address provided here. I understand that some Protected Health Information (PHI) may be shared in the content of these messages, and I understand that e-mail is NOT considered a secure method to transmit this information: Initial _______________

CONTACT INFORMATION

Permission is given to *Tegerstrand O & P to contact me by phone for Medicare covered items. Yes No Initial __________*

Responsible Party

Last Name:	First Name:	Relationship to patient:		
☐ Check if same as patient	Address:	City:	State:	Zip:
Primary Phone:	☐ Home	☐ Work	☐ Mobile	E-mail:

Emergency Contact

Last Name:	First Name:	Relationship to patient:		
☐ Check if same as patient	Address:	City:	State:	Zip:
Primary Phone:	☐ Home	☐ Work	☐ Mobile	E-mail:

CLINICAL & REFERRAL INFORMATION

Diagnosis:	Is the patient Diabetic? ☐ Yes ☐ No	Do you have a prescription today? ☐ Yes ☐ No
Referral: ☐ Physician ☐ Physical/Occupational Therapist ☐ Specialist ☐ Self ☐ Other:	Family Physician:	Last Visit: (mm/yy)
Referring Doctor & Facility:	Contact:	Last Visit: (mm/yy)
Physical/Occupational Therapist & Facility:	Contact:	Last Visit: (mm/yy)

INSURANCE INFORMATION

Primary Insurance

Insurance Company:	☐ Private	☐ Medicaid	☐ Medicare	☐ Worker's Comp
ID#:	Group #:	☐ Other:		
Subscriber's name:	Subscriber's DOB:	Subscriber's SSN:		
Relationship to patient:	Employer:			

Secondary Insurance

Insurance Company:	☐ Private	☐ Medicaid	☐ Medicare	☐ Worker's Comp
ID#:	Group #:	☐ Other:		
Subscriber's name:	Subscriber's DOB:	Subscriber's SSN:		
Relationship to patient:	Employer:			

Tertiary Insurance

Insurance Company:	☐ Private	☐ Medicaid	☐ Medicare	☐ Worker's Comp
ID#:	Group #:	☐ Other:		
Subscriber's name:	Subscriber's DOB:	Subscriber's SSN:		
Relationship to patient:	Employer:			

Signature of Responsible Party: ____ **Date:** ______________________

RETURN TO OFFICE

Tegerstrand Orthotics & Prosthetics

- **Treatment Consent**

I hereby consent to treatment in accordance with my doctor's prescription and authorize Tegerstrand Orthotics & Prosthetics to release medical information necessary to process my claims. I also authorize the payment benefits be made directly to Tegerstrand Orthotics & Prosthetics until my account is paid in full. Accounts not paid ninety days after product delivery will be subject to collection. In order to facilitate treatment initiation, a faxed copy of this form will be acceptable. This consent is in effect until revoked in writing

- **PLEASE READ!!!**

I understand that Tegerstrand Orthotics & Prosthetics is acting solely as an agent for filing insurance benefits assigned to it; however, Tegerstrand Orthotics & Prosthetics assumes no responsibility or guaranteeing payment of covered charges. I understand that I am fully responsible for all deductibles, coinsurance and disallowable. I recognize and affirm my obligation to pay Tegerstrand Orthotics & Prosthetics the total of all charges incurred, and this obligation is in no way dependent upon reimbursement under any medical insurance plan. Any arrangement whereby payments are made directly to Tegerstrand Orthotics & Prosthetics through any insurance plan shall not affect my obligation to pay the remaining balance. I understand that I am responsible for all collections costs, including collection agency fees, attorney fees and court costs associated with collection efforts for any amounts past due to Tegerstrand Orthotics & Prosthetics

- **Protocol For Resolving Complaints From Medicare Beneficiaries**

The patient has the right to freely voice grievances and recommend changes in care or services without fear of reprisal or unreasonable interruption of services. Service, equipment, and bill complaints will be communicated to management and upper management. There complaints will be documented in the Medicare Beneficiaries complaint Log, and completed forms will include the patient's name, address, telephone number, and health insurance claim number, a summary of the compliant, the date it was received, the name of the person receiving the complaint, and a summary of actions taken to resolve the complaint. All complaints will be handled in a professional manner. All logged complaints will be investigated, acted upon, and responded to in writing or by telephone by a manager within a reasonable amount of time after the receipt of the complaint. If there is no satisfactory resolution of the complaint, the next level of management will be notified progressively and up to the president or owner of the company. The patient will be informed of this complaint resolution protocol at the time of set-up of services.

- **Return, Adjustments, Patient Privacy, and Complaint Polices, Patient Bill of Rights and Responsibility**

I have been offered a copy of Tegerstrand Orthotics & Prosthetics Return, Adjustment. Patient Privacy and Complaint Polices, Patient bill of Rights and Responsibility and I understand and agree to these terms and conditions.

- **HIPAA Privacy and Medicare Standards**

I certify that I have been offered a copy of Tegerstrand Orthotics & Prosthetics Notice of Privacy Practices and Medicare Standards. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information (PHI) that may occur in my treatment, payment of my bills or in the performance of Tegerstrand Orthotics & Prosthetics health care operations. The Notice of Privacy Practices also describes my rights and Tegerstrand Orthotics & Prosthetics duties with respect to my PHI. The Notice of Privacy Practices is posted in the waiting room at Tegerstrand Orthotics & Prosthetics. Tegerstrand Orthotics & Prosthetics reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office at 530-241-4040 and requesting a revised copy be sent in the mail or by asking for one at the time of my next appointment.

- **Please Note: For insurance purposes, it is very important that we have as much information as possible. Incomplete forms can result in the delay of your claim being processed.**

I certify that the information for medical insurance is correct. I agree to notify Tegerstrand Orthotics & Prosthetics of any changes in my insurance coverage during the course of the patient's treatment. I certify that I am a patient or duly authorized to act as a patient's agent to execute and accept the above terms and conditions.

- **Assignment of Benefits and Release of Information**

I authorize the release of any medical information necessary to process any claims for services or products received through Tegerstrand Orthotics & Prosthetics. I authorize Tegerstrand Orthotics & Prosthetics to be paid all insurance benefits payable for orthotics-prosthetic services and durable medical equipment and supplies rendered to the patient by Tegerstrand Orthotics & Prosthetics. If payment(s) for insurance benefits are made directly to the patient/guarantor, the payee will indorse and remit all checks to Tegerstrand Orthotics & Prosthetics.

- **Medicare Assignment of Benefits**

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for covered insurance services to the organization furnishing the services or authorize such organization to submit a claim to Medicare for payment.

Printed Name of Patient: ____

Signature of Responsible Party: ______________________________ Date: ______________

Welcome to our office!

Please take the time to review the enclosed documents, which include our company's Returns & Adjustments Policy, Patient's Bill of Rights, Notice of Privacy Practices, and Medicare Supplier Standards. If you would like a copy of any of the documents in this booklet they are available upon request at any of our office locations. We can also submit these to you electronically if that is your preference. Please notify one of our staff members with any requests.

Did you know that the date of service for your insurance claim is the date that we deliver orthotics or medical equipment to you or your family member?

It's true!!

This is very important information to consider because it may have a serious impact on your financial obligation with your claim, particularly if your insurance changes or terminates before the date of service.

Financial Obligation

If you have any questions about this or any other issue with your claim, please speak with one of our representatives and rest assured, that with your help, your claim will be processed with the utmost care.

Questions?

PATIENT COPY

Returns & Adjustments

We do our best to make sure that you are satisfied with every visit. However, a device may need to be returned or adjusted sometime.

IT IS OUR POLICY TO ACCEPT RETURNS AS FOLLOWS:

1

A custom, customized or modified device can only be returned if it does not comply with the physician's prescription.

2

In case of suspected manufacture defect: Item must be brought back clean, item will be returned to the manufacture where they will check for any defects. If defective; the item will be replaced with the same. **Returns other than suspected defects:** The item must be returned within 7 days. Items must be unworn, have original tags attached, in original packaging and in resalable condition.

3

An unused, over-the-counter, unmodified device can be returned for credit within 15 days if accompanied by a receipt.

4

Refunds will be made as follows:

» If the original purchase was made by cash or personal check, a refund will be made by check and sent by mail.

» If the original purchase was made by credit card, a credit will be issued for the original amount.

ADJUSTMENTS TO ORTHOTIC DEVICES:

The components of devices are guaranteed under normal use for 90 days, Tegerstrand Orthotics & Prosthetics will make any repairs to your device, as needed, and free of charge during the warranty period. This does not apply to changes in physical weight, condition, nor any other physiological changes that may occur, or to any alterations made by anyone other than Tegerstrand Orthotics & Prosthetics.
In addition, Tegerstrand Orthotics & Prosthetics will not be responsible for abuse, neglect, or normal wear and tear. Please contact us with any questions or concerns at:

Redding: (530) 241-4040 **Mt. Shasta:** (530) 926-0560 **Chico:** (530) 965-5164

Patient’s Bill of Rights

1. To select those who provide your prosthetic and orthotic services.
2. To be provided with legitimate identification by any person who enters your residence to provide home care services to you.
3. To receive the appropriate and/or prescribed service in a professional manner without discrimination relative to your age, sex, religion. Ethnic origin, sexual preference or mental handicap.
4. To be treated fairly and respectfully by every employee who provides treatment or services to you, and to free of mental and/or physical abuse.
5. To assist in the development and planning of your health care program that is designed to satisfy your current needs.
6. To be provided with adequate information from which to give your consent for the commencement of service, the continuation of service, the transfer of service to another health care provider or termination of services.
7. To express concerns or grievances to your Prosthetist or Orthotist without fear of reprisal.
8. To request and receive complete and up-to-date information relative to your condition, 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 company policies, procedures and changes.
10. To refuse treatment, within the boundaries set by law, and received professional information relative to the ramifications or consequences that will or may result due to such refusal.
11. To request and receive data regarding treatment, services, or costs thereof privately and with confidentiality.
12. To request and receive the opportunity to examine or review your medical records.
13. Have an advocate directive for medical care, such as a living will or the designation of a surrogate decision-maker, respected to the extent provided by the law.
14. Be advised of the telephone number and hours of operation of the states insurance fraud “Hotline.” The hours are 9AM to 5PM and the number is (800) 927-HELP
15. Be advised of the telephone number for Medicare complaints (800) 633-4227
16. Be advised of the telephone number and hours of operation of the accreditation organization ABC. The hours are Monday through Friday from 8AM to 5PM and the telephone number is (703) 836-7114.

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect January 1, 2016 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and healthcare operations. For example:

TREATMENT: We may use and disclose your health information to a physician or other healthcare provider providing treatment to you; including coordination, consultation or referral of a patient for health care from one provider to another.

PAYMENT: We may use and disclose your health information to obtain payment for services we provide to you; including organizing and submitting claims to insurance companies, medical necessity determinations and reviews, utilization review and collection of outstanding accounts.

HEALTHCARE OPERATIONS: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare providers, evaluating practitioner performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

YOUR AUTHORIZATION: In addition to our use of your health information for treatment, payment and healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it is in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

PERSONS INVOLVED IN YOUR CASE: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up your items of health information.

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USES AND DISCLOSURES OF HEALTH INFORMATION CONTINUED

MARKETING: In most instances, we cannot use or disclose your health information for marketing purposes or sell your health information without your written authorization.

REQUIRED BY LAW: We may use or disclose your health information when we are required to do so by federal, state or local law.

RESEARCH: We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.

WORKER'S COMPENSATION: We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

PUBLIC HEALTH RISKS: We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, non-accidental physical injuries, reactions to medications or problems with products.

HEALTH OVERSIGHT ACTIVITIES: We may disclose health information to a health oversight agency for audits, investigations, inspections or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs and compliance with civil rights laws.

LAWSUITS AND DISPUTES: If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

LAW ENFORCEMENT: We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

CORONERS, MEDICAL EXAMINERS AND FUNERAL DIRECTORS: We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may disclose your health information to funeral directors to carry out their duties. We may disclose your health information for organ, eye or tissue donation purposes.

INFORMATION NOT PERSONALLY IDENTIFIABLE: We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

ABUSE OR NEGLECT: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of other.

NATIONAL SECURITY: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose, to authorize federal officials health information required for lawful intelligence, counterintelligence and other national security activities. We may disclose to a correctional institution or a law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

APPOINTMENT REMINDERS: We may use or disclose your health information to provide you with appointment reminders (such as voice mail messages, postcards or letters).

Any other use or disclosure of private health care information, other than those listed above will only be made with written authorization which will specifically identify the information we seek to use/disclose and how we seek to use/disclose it. Authorization may be revoked at any time, in writing, except for the extent that we have already used/disclosed the information in reliance on the authorization

PATIENT RIGHTS

NOTIFICATION IN THE CASE OF A BREACH: We are required by law to notify you in the event of a breach of your unsecured protected health information.

ACCESS: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter, fax or email to the address at the end of this Notice. If you request copies we will charge you $0.50 for each page, $25.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. Information held electronically will be provided in electronic form if requested. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

DISCLOSURE ACCOUNTING: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

RESTRICTION: You have the right to request that we place additional restrictions on our use or disclosure of your health information for purposes of treatment, payment, health care operations or communications with family. Generally, we are not required to agree to a restriction. However, we must agree to a restriction that we will not disclose your private health care information to a health plan for payment if you have paid in full for the service/device provided in that visit.

ALTERNATE COMMUNICATION: You have the right to request that we communicate with you about your health information by alternative means or alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

AMENDMENT: You have the right to request that we amend your health information. (Your request must be in writing and it must explain why the information should be amended.) We may deny your request under certain circumstances.

ELECTRONIC NOTICE: If you receive this Notice on our website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

All customers have the right to lodge complaints without fear or discrimination or reprisals and to know the disposition of complaints. The organization has the responsibility to respond to those complaints promptly and to resolve complaints whenever possible to the satisfaction of the individual. Should you wish to file a complaint or to praise us about our products or services, see any of the staff members or call us at (530) 241-4040. If you complaint is not resolved by calling, you can call one of the following numbers

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Privacy Contact: Becky Tegerstrand
2102 Civic Center Drive, Redding CA 96001- Phone 530-241-4040 Fax 530-241-4092

If your complaint is not resolved by calling, you can call one of the following numbers:

State Hotline:	Medicare:	ABC (accrediting organization)
(800) 927-HELP	(800) MEDICARE	(703) 836-7114
(800-927-4357)	(800- 633-4227)	

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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.

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. 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, cell phone 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.

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