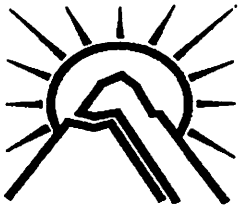


Prevail Prosthetics & Orthotics

Height:_____

Weight:_____

Patient Information (please print)

Patient Name:_____ Patient ID:_____

S.S. # :_____ Date of Birth:_____ Gender: Male Female

Address:_____

City State Zip

Phone:_____ Email:_____

Does the patient currently live in a Skilled Nursing Facility? Yes No If yes, please list:_____

MEDICARE PATIENTS: Have you had a brace/prosthetic in the past? Yes No

Insurance Information (if same as above, write same)

Policy Holders Name:_____

Address:_____

City State Zip

Phone:_____ Relationship to Patient:_____

Date of Birth:_____ SSN:_____

Employer:_____

In Case of Emergency Contact:

Name:_____ Relationship:_____

Phone:_____

Medical Information

Referring Doctor:_____ Primary Care Doctor:_____

Is the patient Diabetic? Y N Diabetic Dr:_____

Physical/Occupational Therapy Facility (if applicable):_____

If you're receiving an item for your foot/leg, please provide your shoe size: _____

Employment

Patient's Employer:_____ Phone:_____

May we contact you at work? Yes No

******Please Read******

I understand that Prevail is acting solely as an agent for filing insurance benefits assigned to it: however, Prevail assumes no responsibility for guaranteeing payment of covered charges. Benefits quoted to me from Prevail are strictly that, a quote. Charges may be incurred per the insurance carrier. I understand that I am fully responsibility for all deductibles, coinsurance, and disallowable at the time services are rendered. I recognize and affirm my obligation to pay Prevail the total of all charges incurred, and this obligation is in no way dependent upon reimbursement from my medical insurance plan. Any arrangement whereby payments are made directly to Prevail through any insurance plan shall not affect my obligation to pay the remaining balance. I authorize the release of any medical information necessary to process this claim through Prevail Prosthetics & Orthotics, Inc. I understand this authorization expires one year from the date of signature and is valid beginning the date of signature. I have the right to revoke this authorization at any time, in writing. I acknowledge that I have received the Supplier Standards, HIPAA Privacy Information and the Patient's Bill of Rights and Responsibilities.

_____

Signature of Patient, Parent/Guardian, or Authorized Representative Date

Prevail Prosthetics & Orthotics Payment Policy & Fee Notification

I understand that it is my responsibility to know who my insurance carrier is in and out of network with. I acknowledge I am responsible for payment if my insurance carrier deems the procedure is out of network. Prevail is acting as an agent for filing insurance benefits assigned to it however, Prevail assumes no responsibility for guaranteeing payment from my insurance carrier. I also acknowledge that, if they are not contracted to do so, Prevail is under no obligation to file an insurance claim or write appeals on my behalf, and does so as a courtesy. I understand that I am fully responsible for all deductibles, co-insurance and all other fees, including non-covered charges. I recognize and affirm my obligation to pay Prevail the total for all charges incurred, and this obligation is in no way dependent upon reimbursement from any insurance plan. Any arrangement whereby payments are made directly to Prevail through any insurance plan shall not affect my obligation to pay the remaining balance.

FEES AND PAYMENTS

Our goal is to provide the best orthotic and prosthetic care and services. We make every effort to keep our fees reasonable and to avoid unfairly passing on to our patients the cost of unnecessary collection procedures. Therefore, all co-pays, co-insurance and deductibles are due at the time services are rendered. There will be a late fee of $10 per month on any amount past due. There will also be a $20.00 fee for all bounced/returned checks. In the event that a collection agency must intervene due to non-payment, you will be responsible for any court costs, late fees and reasonable attorney fees.

INSURANCE/VA

Please remember that your insurance policy is a contract between you (as a policy holder) and the insurance carrier. It does not release you of financial responsibility for services rendered and is not a substitute for payment. We do accept insurance assignment.

Private Insurance Assignment of Benefits: I hereby authorize my insurance company to make payment directly to Prevail for all services they provide me.

VA patients: By signing this you are authorizing us to file a claim with the VA and authorizing them to make payment directly to Prevail.

If we have a purchase order on file, you have already been approved for your service.

STATE MEDICAL ASSISTANCE (MEDICAID)

We are a licensed provider for Medicaid in the State of Indiana. We will verify your coverage and obtain all necessary authorizations. Some Medicaid patients have a spend-down and may be required to pay some expenses out-of-pocket. If you do not know if you have a spend-down, please ask our office staff for assistance in obtaining this information.

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 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.

WORKER'S COMPENSATION

If your equipment has been prescribed due to a work related injury and is to be turned in under workman's compensation, we need to have a name and phone number of someone we can contact before we issue your prosthetic or orthotic device. If we can not verify coverage or if the coverage is in question, you may be asked to pay for the device in full on the day the service is rendered.

AUTOMOBILE INSURANCE

If the device we are providing is a result of an injury from an auto accident, we will need phone numbers, claim numbers, and names of all insurance companies involved. Generally, the auto insurance companies pay the insured for services, or the claim turns into a legal issue.

We ask that you pay in full for the device that we provide you at the date of service.

If the carrier does send payment directly to Prevail, we will gladly refund any money due to you.

I, as the patient or responsible party, have read and understand the above and authorize the release of information for the purpose of reimbursement of insurance benefits. I realize I am responsible for any charges incurred in this facility.

I authorize the release of any medical information necessary to process claims.

Signature of patient/responsible party Date

PRIVACY PRACTICES ACKNOWLEDGMENT

ACKNOWLEDGMENT FORM

I have received the Notice of Privacy Practices (HIPAA) and/or have been provided the opportunity to review it.

I have received the Patient Bill of Rights and Responsibilities, and/or have been provided the opportunity to review it.

Patient's Name: _____ Date of Birth: _____

Signature of Patient or Parent/Guardian: _____

Date: _____

Prevail has my permission to release medical and/or payment information to the following:

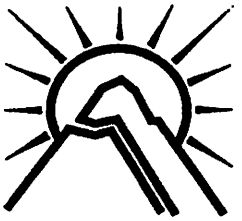
Name:_____Relationship:_____Phone:_____

Name:_____Relationship:_____Phone:_____

Name:_____Relationship:_____Phone:_____

Name:_____Relationship:_____Phone:_____

Name:_____Relationship:_____Phone:_____



Prevail Prosthetics & Orthotics

A Buck Toenges Company

FRED WM. "BUCK" TOENGES, C.P.O.
JOHN LEE, C.O.
KRISTOFFER H. KAIL, C.P.O
LARRY LIBBEE, CO, ATC
ADAM EDMONDS, C.O.
STEPHANIE JONES-CUTLER, C.P.

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

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

Previous Name: _____ **Social Security #:** _____

This authorization applies to Prevail Prosthetics & Orthotics for the following records:

☐ **Healthcare information relating to the following treatment, condition or dates:** _____

_____

☐ **All healthcare information**

☐ **Other:** _____

_____

Definition: **Sexually Transmitted Disease (STD, as defined by law, RCW 70.24, includes herpes, herpes simplex, human papilloma virus, warts, genital warts, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, HIV (Human Immunodeficiency Virus) AIDS (Aquired Immunodeficiency Symdrome) and gonorrhea.)**
I understand that medical records may contain information regarding STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above and by signing this form I authorize release of said information. I understand that Prevail can not release this information to anyone without my written permission. I further understand that records may also contain information regarding drug, alcohol, or mental health treatment to the person(s) listed above.

I have the authority to revoke this authorization at any time and must do so in writing to Prevail Prosthetics & Orthotics.

There is a potential that the information we are given can or will be re-disclosed to other parties who request them, such as the insurance carrier(s) in compliance with HIPAA regulations.

_____ _____
Signature of Patient or Parent/Guardian if minor **Date**

_____ _____
Printed Name **Relationship to patient**

Authorization expires 1 year after signature date