

# Patient Information Sheet



Select Office Location:

Arcadia  Downey  Long Beach  Orange Co.

## PATIENT INFORMATION

FIRST NAME		MIDDLE INITIAL	LAST NAME		DATE OF BIRTH	SOCIAL SECURITY NUMBER	
ADDRESS		APT#	CITY		STATE	ZIP	
( )		( )					
HOME PHONE NUMBER		CELL PHONE NUMBER		BEST TIME TO REACH YOU			
E-MAIL ADDRESS			MALE / FEMALE	MARITAL STATUS	HEIGHT	WEIGHT	
DRIVER'S LICENSE #	STATE	EXP DATE	OCCUPATION				
EMPLOYER			( )				
EMPLOYER			EMPLOYER PHONE				
EMERGENCY CONTACT			( )				
EMERGENCY CONTACT			PHONE NUMBER				

<b>INSURANCE INFORMATION</b>	Medicare	Medi-Cal	CCS	HMO	PPO	Private	VA	Cash	Other
NAME OF PRIMARY PHYSICIAN					( )				
NAME OF REFERRING PHYSICIAN (IF DIFFERENT)					PHYSICIAN PHONE NUMBER				
					( )				
					PHYSICIAN PHONE NUMBER				

\*\*\*\*\*THE FOLLOWING INSURANCE INFORMATION MUST BE FOR THE INSURED PARTY:

PRIMARY INSURANCE	MEMBER ID#	MEMBER SS# AND DATE OF BIRTH
SECONDARY INSURANCE	MEMBER ID#	MEMBER SS# AND DATE OF BIRTH
DOES THE PATIENT HAVE A CCS CASE? YES NO	IF YES, WHAT IS THE CASE NUMBER? _____	

WERE YOU INJURED AT WORK? YES NO		
NAME OF EMPLOYER AT TIME OF INJURY	DATE OF INJURY	
NAME OF WORKER'S COMPENSATION CARRIER	CLAIM NUMBER	

### PLEASE READ THE FOLLOWING AND SIGN BELOW

I hereby authorize Orthotic/Prosthetic services prescribed by my physician. I hereby authorize Human Designs to furnish my insurance company with all information they request. I also instruct my insurance company to issue payment of my claim directly to Human Designs. I understand that if my insurance company requires authorization and I choose to receive services before the written authorization has been received by Human Designs, I will accept financial responsibility for all charges. **I understand that even if services are authorized, but I am not eligible on the date of service, or if it is later determined that my policy does not cover the item(s) I am receiving, I WILL BE RESPONSIBLE FOR PAYMENT IN FULL.** I further understand that my insurance company may deduct a CO-INS, SHARE OF COST or DEDUCTIBLE from their payment to Human Designs, and I agree to pay PROMPTLY for these amounts. I understand that items received may not be returned or payments refunded in order to reduce my financial responsibility. My signature also represents my permission for my doctor, medical group, and/or hospital to release any medical records necessary for the processing of my claim(s).

PATIENT OR PERSONAL REPRESENTATIVE \_\_\_\_\_ DATE \_\_\_\_\_

Office Use Only:

**THIS INFORMATION IS REQUIRED TO DETERMINE COVERAGE OF SERVICE TO BE PROVIDED**



Has the patient ever received the same or similar device?      Yes      No

If yes, list the device provided: \_\_\_\_\_

Did Human Designs provide the device? \_\_\_\_\_

Estimated Date Provided: \_\_\_\_\_

Was device returned to original supplier?      Yes      No

Is the device being replaced?      Yes      No

Is there new medical necessity?      Yes      No

Describe condition for previous need \_\_\_\_\_

Describe new/changed condition \_\_\_\_\_

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**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I certify that I have received a copy of the Human Designs' Notice of Privacy Practices (Notice). The Notice describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills, or in the performance of Human Designs' health care operations. The Notice also describes my rights and Human Designs' duties with respect to my protected health information. The Notice is posted in patient treatment rooms and on Human Designs' website at [www.humandesigns.com](http://www.humandesigns.com).

Human Designs reserves the right to change the privacy practices that are described in the Notice. I may obtain a revised Notice by calling the office and requesting a revised copy to be sent in the mail, asking for one at the time of my appointment, or accessing Human Designs' website.

I have received the Medicare Supplier Standards     Yes     No

\_\_\_\_\_  
SIGNATURE OF PATIENT OR PERSONAL  
REPRESENTATIVE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PRINT NAME OF PATIENT OR PERSONAL  
REPRESENTATIVE

\_\_\_\_\_  
DATE

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**INSURANCE INFORMATION**

We will verify your insurance for the device prescribed by your physician and advise you of the benefit information we receive from your insurance company. We are not responsible for incorrect benefit information provided to us by your insurance during the verification process. Please refer to your benefits book and/or consult your insurance carrier for further details and assistance.

\_\_\_\_\_  
SIGNATURE OF PATIENT OR PERSONAL  
REPRESENTATIVE

\_\_\_\_\_  
DATE

A. Notifier:

B. Patient Name:

C. Identification Number:

### Advance Beneficiary Notice of Noncoverage (ABN)

**NOTE:** If Medicare doesn't pay for D. \_\_\_\_\_ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D. \_\_\_\_\_ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

**WHAT YOU NEED TO DO NOW:**

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D. \_\_\_\_\_ listed above.

**Note:** If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

**G. OPTIONS: Check only one box. We cannot choose a box for you.**

- OPTION 1.** I want the D. \_\_\_\_\_ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
- OPTION 2.** I want the D. \_\_\_\_\_ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.
- OPTION 3.** I don't want the D. \_\_\_\_\_ listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

**H. Additional Information:**

**This notice gives our opinion, not an official Medicare decision.** If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

<b>I. Signature:</b>	<b>J. Date:</b>
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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Human Designs Prosthetics and Orthotics  
Main Office  
2933 Long Beach Boulevard  
Long Beach CA 90806

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### CONFIDENTIAL REQUEST FOR MEDICAL RECORDS

I understand that the following release is to be used between Human Designs Prosthetics and Orthotics, and my prescribing physician to obtain records, if necessary in order to provide information to Human Designs or to my insurance company.

To: \_\_\_\_\_  
(Referring Physician's Name)

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I hereby request that my medical records be released to: Human Designs Prosthetics and Orthotics  
*(choose office location below)*

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Long Beach<br>2933 Long Beach<br>Long Beach CA<br>Ph: 562 988-2414<br>Fx: 562 490-2831 | <input type="checkbox"/> Arcadia<br>49 E Foothill Blvd<br>Arcadia CA 91006<br>Ph: 626 445-7797<br>Fx: 626 445-7873 | <input type="checkbox"/> Tustin<br>1541 Parkway Loop<br>Tustin CA 92780<br>Ph: 714 258-8144<br>Fx: 714 258-8140 | <input type="checkbox"/> Downey<br>8734 Cleta St. Unit C<br>Downey CA 90241<br>Ph: 562 988-2414<br>Fx: 562 490-2831 |
|---|--|---|---|

Patient's Printed Name: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\*This request is valid for one year from the patient signature date. Expiration Date: \_\_\_\_\_

## 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. 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.