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 PHONE

EMERGENCY CONTACT (________)________ PHONE NUMBER

INSURANCE INFORMATION Medicare Medi-Cal CCS HMO PPO Private VA Cash Other

NAME OF PRIMARY PHYSICIAN (________)________ PHYSICIAN PHONE NUMBER

NAME OF REFERRING PHYSICIAN (IF DIFFERENT) (________)________ 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____

ACKNOLWEGDEMENT 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.

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

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.

I. Signature:	J. Date:

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.

LOWER LIMB PROSTHETIC ASSESSMENT FORM

PATIENT INFORMATION

Name: ______________________ Evaluation Date: ______________

D.O.B. ______________________ Practitioner: ______________

Height: ______________________ Location of Patient Evaluation:

Weight: ______________________ ☐ Office ☐ Rehab Hospital ☐ Home

Sex: ☐ Male ☐ Female ☐ Skilled Nursing Facility ☐ Other

INITIAL OBSERVATION AND DIAGNOSIS

Amputation Date: ______________ Referring Physician: ______________

Amputation Side: ☐ Right ☐ Left ☐ Bilateral Date of Last Appointment: ______________

ICD-9 Amputation Level

895.00 ☐ Toe	897.2 ☐ Trans-Femoral
896.00 ☐ Partial Foot	897.4 ☐ Hip Disarticulation
896.00 ☐ Ankle Disarticulation	897.4 ☐ Pelvic Disarticulation
897.00 ☐ Trans-Tibial	897.4 ☐ Not otherwise specified
897.20 ☐ Knee Disarticulation	897.6 ☐ Bilateral

Cause of Amputation

☐ Diabetes	☐ Motor Vehicle Accident	☐ Congenital
☐ Cardiovascular disease	☐ Peripheral vascular disease	☐ Other______________
☐ Trauma		

TYPE OF SERVICE

New Patient/Service:	☐ Yes ☐ No		
Replacement:	☐ Entire ☐ Socket ☐ Components______________________________		
Replacement Due To:	☐ Change in Residual Limb	☐ Functional Activity Level	☐ Wear & Tear
	☐ Weight Gain ☐ Loss	☐ Irreparable Damage	☐ Other:_____
Type of Prosthesis :	☐ IPOP	☐ Definitive	☐ Cosmetic
	☐ Prepatory	☐ Sport	☐ Endoskeletal
	☐ Exoskeletal	☐ Other:	
Details:			

MD Signature________________

DAILY LIVING INFORMATION

Living Status:	☐ Alone in Home ☐ Home with Spouse/Family ☐ Long Term Care Facility ☐ Other
Living Conditions:	☐ Level Surfaces ☐ Level with Steps ☐ Uneven Surfaces ☐ Uneven with Steps
Patient's Vocation:	Seated____% Standing____% Variable Cadence ___%
Recreation:	☐ Bicycling ☐ Walking ☐ Sports ☐ Swimming ☐ Running ☐ Aerobics ☐ Shopping ☐ Domestic Chores ☐ Other ______________
Physical Therapy:	☐ Does not go ☐ Ongoing ☐ Needed ☐ Pt would like a referral
Current Assistive Devices Used:	☐ Handrails Present (home) ☐ Walker ☐ Cane ☐ Ramps present (home) ☐ Crutch(s) ☐ Wheelchair
Transportation Used:	☐ Drives own car ☐ Rides in Car ☐ Buses ☐ Trains ☐ Other
Desire to Ambulate:	Describe patients pre-amputation status: Is the patient motivated to ambulate: ☐ Yes ☐ No Describe the patients level of motivation to ambulate:

PROSTHETIC HISTORY

☐ Patient has never worn a prosthesis
☐ Patient currently has a prosthesis

Number of years patient has worn a prosthesis:______year(s)

Age of current prosthesis:_________month(s) or ______years(s)

Daily wearing schedule: ______hours per day

Design and condition of current prosthesis: ☐ N/A

☐ Endoskeletal ☐ Exoskeletal

Socket: ____________________ ☐ *Acceptable as is*
☐ *Needs to be replaced because:*

Knee: ____________________ ☐ *Acceptable as is*
☐ *Needs to be replaced because:*

Suspension: ____________________ ☐ *Acceptable as is*
☐ *Needs to be replaced because:*

Foot/Ankle: ____________________ ☐ *Acceptable as is*
☐ *Needs to be replaced because:*

Describe condition of current prosthesis: ____________________

Does present prosthesis meet patient's current needs? (Function, safety, etc.) ☐ N/A ☐ Yes ☐ No
If no, explain: ____________________

RESIDUAL LIMB HEALTH

Length Overall:	________ ☐ inches ☐ cm		
Tissue Consistency:	☐ Soft	☐ Medium	☐ Firm
Skin Condition:	☐ Normal	☐ Discoloration	☐ Open Wounds
Limb Shape:	☐ Normal	☐ Bulbous	☐ Conical
Contracture:	☐ Flexion	☐ Abduction	☐ None present
Other:	☐ Scars	☐ Bony Prominence	☐ Neuroma

Residual Limb Measurements: ________________ Circumference ________________ Distance from IT

MD Signature________________

FUNCTIONAL LEVEL ASSESSMENT

K0 ☐ Does not have the ability or potential to ambulate or transfer safely with or without assistance and a prosthesis does not enhance their quality of life or mobility.

K1 ☐ **Household Ambulator:** Has the ability or potential to use a prosthesis for transfers or ambulation on level surfaces at a fixed cadence.

K2 ☐ **Limited Community Ambulator:** Has the ability or potential for ambulation with the ability to traverse low level environmental barriers such as curbs, stairs, or uneven surfaces.

K3 ☐ **Unlimited Community Ambulator:** Has the ability or potential for ambulation with variable cadence. has the ability to traverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion.

K4 ☐ **Child, Active Adult or Athlete:** Has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress, or energy levels.

Patients Existing Environmental Barriers	☐ Level Surfaces ☐ Level with steps ☐ Uneven surfaces ☐ Uneven with steps ☐ Ramps or Slopes ☐ Other
Gait Observations:	

PROSTHETIC RECOMMENDATIONS

Type of Prosthesis Required:	☐ Partial Foot ☐ Symes ☐ Below Knee ☐ Above Knee ☐ IPOP ☐ Preparatory/Temporary ☐ Definitive ☐ Other:

Foot: ______________________________

Rationale:
☐ Reduce Energy Consumption ☐ Increased Stability
☐ Walk on Uneven Terrain ☐ Variable Cadence

Comments: ______________________________

Knee: ______________________________

Rationale:
☐ Reduce Energy Consumption ☐ Increased Stability
☐ Variable Cadence ☐ Increased Comfort

Comments: ______________________________

Suspension: ______________________________

Rationale:
☐ Reduce Skin Abrasion ☐ Increased Stability
☐ Increased Prosthetic Control ☐ Increased Comfort

Comments: ______________________________

Socket: ______________________________

Rationale:
☐ Increase Control ☐ Increased Stability
☐ Increase Muscle Movement ☐ Increased Comfort

Comments: ______________________________

Liner/Insert: ______________________________

Rationale:
☐ Control Volume Change ☐ Increased Comfort
☐ Reduce Stress on Skin ☐ Improved Suspension

Comments: ______________________________

Protective Cover: ☐ Yes ☐ No — ☐ Protect Internal Components ☐ Moisture Protection

Total Contact: ☐ Yes ☐ No — ☐ Increased Venous return ☐ Increased Wt. Bearing Surface ☐ Increased Comfort

MD Signature________________

General Observations and Comments:

MD Signature__________________

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

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)

☐ Long Beach
2933 Long Beach
Long Beach CA
Ph: 562 988-2414
Fx: 562 490-2831

☐ Arcadia
49 E Foothill Blvd
Arcadia CA 91006
Ph: 626 445-7797
Fx: 626 445-7873

☐ Tustin
1541 Parkway Loop
Tustin CA 92780
Ph: 714 258-8144
Fx: 714 258-8140

☐ Downey
8734 Cleta St. Unit C
Downey CA 90241
Ph: 562 988-2414
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.

National Supplier Clearinghouse
P.O. Box 100142 • Columbia, South Carolina • 29202-3142 • (866) 238-9652
A CMS Contracted Intermediary and Carrier