SUPERIOR PROSTHETICS & ORTHOTICS, LLC

821 CLEARWATER LARGO RD N
LARGO, FL 33770
Phone: (727)461-5278
Fax: (727)447-2950

12126 CORTEZ BLVD
BROOKSVILLE, FL 34613
Phone: (352)596-1967
Fax: (352)596-1332

ATTENTION PATIENTS:

This is our current intake packet, we need **ALL** pages **FILLED OUT, SIGNED AND DATED** before we can provide services to you per HIPAA regulations that went into effect April 14th, 2003.

THANK YOU!

HOURS OF OPERATION:

Monday - Friday: 8:00am - 5:00pm

CLOSED for LUNCH DAILY 12:00pm -1pm

Closed Major Holidays

Extended Hours by APPOINTMENT ONLY

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Name: _____ Date: _____ DOB: _____

SSN: _____-_____-_____ Phone Number: (_____)_____-_____

Address: _____ City: _____ Sate: _____ Zip:_____

Is this your address where you originally obtain your Medicare? **Y** or **N** ? If No, what is the address?

Address: _____ City: _____ Sate: _____ Zip:_____

Home Phone:(_____)_____-_____ Cell Phone :(_____)_____-_____Work Phone : (_____)_____-_____

Next of Kin: _____ Relationship: _____ Phone: (_____)_____-_____

Person Financially Responsible: _____ Phone: (_____)_____-_____

Gender: _____ Weight: _____ Height:_____ Medical Necessity? _____

Have you ever been seen by another O&P facility? **Y** or **N** If yes, where: _____

Have you ever received the same or similar supplies/equipment (i.e. braces, shoe, insert)? **Y** or **N**

If yes, when: _____

Referring Physician: _____ Phone: (_____)_____-_____

Family Physician: _____ Phone: (_____)_____-_____

Surgeon (If new amputee): _____ Phone: (_____)_____-_____

Primary Insurance: _____ **ID Number** _____ **HMO?**_____

Secondary Insurance: _____ **ID Number** _____ **HMO?**_____

For Office Use ONLY

Practitioner:
Appointment Date:
Dx:
Rx:
Entered By:

Release of Medical Information

I authorize any holder of medical information in reference to my health be released to Superior Prosthetics & Orthotics. I understand that this information is needed to help diagnose my health needs.

_____

Patient's Name Printed

_____ _____

Patient's Signature Date

SUPERIOR PROSTHETICS & ORTHOTICS

CUSTOM ORDER WAIVER

ALL CUSTOM ORDER ITEMS ARE NON-REFUNDABLE

I hereby assume all responsibility for the payment of any and all custom made items prescribed to me by my physician as medically necessary and furnished to me by Superior Prosthetics & Orthotics. I will have an opportunity to discuss the item prescribed with a practitioner ensure that I am satisfied with the expected performance of said item(s).

Once I have been evaluated and measurements and/or castings have been performed, I shall sign this waiver as acceptance of the assignment prior to the ordering of any items. I am aware that CUSTOM ORDER items require 1/2 cost down as a deposit in order for Superior Prosthetics & Orthotics to order custom items, and the remaining 1/2 balance due at time of delivery.

As such, all responsible and customary allowed expenses incurred by Superior Prosthetics & Orthotics shall be reimbursed directly by myself or by my medical insurance.

_____

Patient's Name Printed

_____ _____

Patient's Signature Date

_____ _____

Practitioner's Signature Date

ASSIGNMENT OF BENEFITS [AOB]

This AOB form is required to bill on your behalf

My signature and date bellow authorizes each of the following:

1. Assignment of Medicare, Medicaid, Medicare Supplemental or other insurance benefits to [Superior Prosthetics & Orthotics, LLC] and/or any of out corporate affiliates for medical supplies and/or medication(s) furnished to me by [Superior Prosthetics & Orthotics, LLC].
2. Direct billing to Medicare, Medicaid, Medicare Supplemental or other insurance.
3. Release of my medical information to Medicare, Medicaid, Medicare Supplemental or other insurers and their agents and assigns.
4. [Superior Prosthetics & Orthotics, LLC] to obtain medical or other information necessary in order to process my claim(s), including determining eligibility and seeking reimbursement for medical supplies and/or medications provided.
5. [Superior Prosthetics & Orthotics, LLC] to contact me by telephone or mail regarding my medical supplies and/or medication(s) order(ed).

I agree to pay all amounts that are not cover by my insurer(s) including applicable co-payments and/or deductibles for which I am responsible.

_____ _____

Name Printed Phone Number

_____ _____

Signature Date

I request that payment(s) of Medicare, Medicaid, Medicare Supplemental or other insurance benefits be made on my behalf to [Superior Prosthetics & Orthotics, LLC] for any medical supplies and/or medications furnished to me by [Superior Prosthetics & Orthotics, LLC]. I authorize any holder of medical information about me be released to [Superior Prosthetics & Orthotics, LLC] , my physician(s), caregiver, CMS its agents and to my primary and/or other medical insurer any information needed to determine or secure eligibility information and/or reimbursement for covered services. I agree to pay all amounts that are not covered by my insurer(s) and for which I am responsible.

Your Medicare Number: _____

Insurer: _____ Policy Number: _____

(Other than or in addition to Medicare)

PATIENT RIGHTS AND RESPONSIBILITIES
CONSENT TO PRIVACY PRACTICES

Patient Rights:

1. The patient has the right to considerate and respectful service.
2. The patient has the right to obtain service without regard to race, creed, national origin, sex, age, disability, diagnosis, or religious affiliation.
3. Subject to applicable law, the patient has the right to confidentiality of all information pertaining to his/her medical equipment service. Individuals or organizations not involved in the patient's care, may not have access to the information without patient's written consent.
4. The patient has the right to make informed decisions about his/her care
5. The patient has the right to reasonable continuity of care and service.
6. The patient has the right to voice grievances without fear of termination of service or other reprisal in the service process.

Patient Responsibilities:

1. The patient should promptly notify the Superior staff of any equipment failure or damage.
2. The patient is responsible for any equipment that is lost or stolen while in their possession and should promptly notify Superior in such instances.
3. The patient should promptly notify Superior of any changes to their address, telephone, and insurance.
4. The patient should notify Superior of discontinuous of use.
5. Except where contrary to federal or state law, the patient is responsible for any equipment rental and sale charges which the patient's insurance company/companies does not pay.

Consent to Privacy Practices of Superior Prosthetics & Orthotics, LLC Effective Date April 14,2003

You have been provided with a copy of Superior Prosthetics & Orthotics, LLC "Notice of Privacy Practices" that describes how we will use health information concerning our service to you. The notice details how we will use this information to provide treatment care for you, to gain reimbursement for our service and to improve our operations to better serve you and other patients.

We are required to document that :

1. We have given you a our Notice of Privacy Practices and that you have had the opportunity to review it.
2. Superior will notify you of changes in our Notice of Privacy Practices prior to implementing those changes.
3. You may request restrictions as to how your health information may be used although Superior is not required to agree to those restrictions.
4. Any restrictions to which Superior agrees to will be respected.
5. You may revoke this consent in writing at any time , although Superior can proceed with uses as disclosure that pertain to treatment, payment or healthcare issues that take place before the consent was revoked.

Please provide your signature below to indicate understanding and consent for use of health information related to our service.

_____	_____
Patient or Legal Representative Printed	Witness Printed
_____	_____
Patient or Legal Representative Printed	Witness Signature
_____	_____
Date	Date

To Request a restriction on the use and disclose of your personal health information related to your treatment, payment for services, or for the health care operations of Superior please do so after reading the Notice of Information Practices. You may use this consent form to request restriction.

I request the following restrictions to use or disclosure of my health information

_____

THE PROVIDER USE ONLY

Restriction is:

☐ ACCEPTED
☐ DENIED

Reason Denied: _____

Patient Notified:

☐ YES
☐ NO

_____

EFFECTIVE DATE: _____

Please provide your signature below to indicate understanding and consent for use of health information related to our service.

_____
Patient or Legal Representative Printed

_____
Witness Printed

_____
Patient or Legal Representative Printed

_____
Witness Signature

_____
Date

_____
Date

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name: _____ **D.O.B :** _____

Phone (Home): _____ **Phone (Work):** _____

Address: _____ **City/State/Zip:** _____

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name: _____ **Facility Phone:** _____

Facility Address: _____**City/State/Zip:** _____

Facility Fax: _____

Dates and Type of Information to Disclose:

- ☐ 2 years prior from last date seen
- ☐ Dates Other: _____
- ☐ Specific Information Requested:

_____

Purpose of Disclosure is:

- ☐ Change of Insurance or Physician
- ☐ Continuation of Care (e.g., VA Med Ctr.)
- ☐ Referral
- ☐ Other: _____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested.This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I UNDERSTAND THE INFORMATION IN MY HEALTH RECORD MAY INCLUDE INFORMATION RELATING TO SEXUALLY TRANSMITTED DISEASE, ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS), OR HUMAN IMMUNODEFICIENCY VIRUS (HIV). IT MAY ALSO INCLUDE INFORMATION ABOUT BEHAVIORAL OR MENTAL HEALTH SERVICES, ADN TREATMENT FOR ALCOHOL AND DRUG ABUSE.

This information may be disclosed and used by the following individual or organization:

Release To: _____ **Address:** _____

City/State/Zip: _____ **Phone:** _____ **Fax:** _____

- ☐ **Please Mail Records**
- ☐ **Please Fax Records**

I understand I may revoke this authorized at any time.I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest and claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition._____.
If I fail to specify any expiration date, event, or condition, this authorization will expire 1 year from date signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing authorization for release of information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____ _____

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

_____ _____

Printed Name of Authorized Representative **Relationship to Patient**

_____

Address and Telephone number of authorized Representative

Notification of Information Practices

The purpose of the consent is to inform you, the patient, how you personal health information is used and/or disclosed by this provider organization. We want you to be fully aware of what we do with your information so that you can provide us with your consent in order for us to treat your healthcare needs, receive payment for services rendered, and allow administrative and other types of health care operations to happen, which are part of normal business activities or the provider or organization.

Your Consent

I understand that as part of my health care, this organization originates and maintains health records describing my health history, symptoms, test results, diagnoses, treatment, and plans for future care or treatment. I understand that is information serves as:

- A basis for planning my care and treatment
- A means of communication among my diagnosis/es and other health information to my bill(s)
- A source of information for applying my diagnosis/es and other health information to my bill(s)
- A means by which my health plan or health insurance company can verify that services billed were actually provided.
- A tool for routine health care operations in this organization, such as ensuring that we have equality processes and programs in place and make sure that the professionals who provide the care are competent to do so.

I UNDERSTAND THAT:

- I have been provided with a notice of information practices that provides specific examples and descriptions of how my personal health information is used and disclosed by Superior Prosthetics & Orthotics, LLC
- I have the right to review the notice of information prior to signing this consent.
- Superior can change its notice of information but notify me of those changes before they are put into practice and will mail me a copy of the new notice to the address that I have provided.
- I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations and that Superior is not required to agree to agree to those restrictions.
- Any restrictions to which Superior agrees to will be respected.
- I may revoke this consent in writing at any time. Further, I am aware that Superior can proceed with uses and disclosures that pertain to treatment, payment, or healthcare issues that took place before the consent was revoked.

HIPAA Notices of Privacy Practices
Your Information. Your Rights. Our Responsibilities.

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

You have the right to:
- Get a copy of your paper or electronic medical records
- Correct your paper or electronic medical records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

You have some choices un the way that we use and share information as we:
- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our service and sell your information
- Raise funds

We may use and share your information as we:
- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation request
- Work with a medical examiner or funeral director
- Address workers compensation, law enforcement, and other government requests.
- Respond to lawsuits and legal action.

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical records
- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical records
- You can ask us to correct your health information about you that you think is incorrect or incomplete. Ask us how to do this?
- We may say “no” to your request, but we will tell you why in writing within 60 days.

Request confidential communications
- You can ask us to contact you in a specific way (for example: home or office phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

Ask us to limit what we use or share
- You can ask us not use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, we Amy say “no” if it would not affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we’ve shared information
- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost based fee if you ask for another one within 12 months.

Get a copy of this privacy notice
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated
- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6675, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/**.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information , you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you
We can use your health information and share it with other professionals who are treating you. *Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

Run our organization
We can use and share your health information to run our practice, improve your care, and contact you when necessary. *Example: We use health information about you to manage your treatment and services.*

Bill for your services
We can use and share your health information to bill and get payment from health plans or other entities. *Example: We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information?

We are allowed or required to share your information in other ways — usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medication
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone/s health or safety

Do Research
We can use or share your information for health research

Comply with the law
We will share information about you if the state or federal law requires it, including the Department of Health and Human Services if it wants to see if we are complying with federal privacy law.

Respond to organ and tissue donation request
We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director
We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions
We can share information about you in a response to a court or administrative order, or ink response to a subpoena.

Our Responsibilities
- We are required by law to maintain the privacy and security of our protected health information
- We will let you know promptly if a breach occurs the may have compromised the privacy or security of your information
- We must follow the duties and privacy practices describes in this notice and give you a copy of it.
- We will not use or share your information other then the described here unless you tell us we can in writing. If you tell us we can, you may change your mind at anytime. Let us know in writing if/when you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hippa/understanding/consumers/noticepp.html

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

Other Instructions for Notice

- Insert effective date for this notice
- Insert name or title of the privacy official (or other privacy contact) and his/her email address and phone number.
- Insert any special notes that apply to your entity's practices such as "we never market or sell personal information"
- The privacy rule requires you to describe any state or other laws that require greater limits on disclosures. For example, " we will never share any substance abuse treatment records without your written permission." Insert this typer of information here. If no laws with greater limits apply to you entity, no information is needed to be added.
- If your entity provides patient with access to their health information via the Blue Button protocol, you may want to insert a reference to it here.
- If your entity is part of an OHCA (Organized Health Care Arrangement) that has agreed to a joint notice, use this space to inform your patients on how you share information within the OHCA (such as treatment, payment, and operations related to OHCA.) Also, describe the other entities covered by tis notice and their service locations. For example:, " This notice applies to Grace Community Hospitals and Emergency Services Incorporated which operate the emergency service within all Grace hospitals in the greater Dayton area."

Report Abuse

Any person who knows, or has reasonable cause to suspect, that a person with a developmental disability is being abused, neglected, or exploited by a relative, caregiver, or household member or, in the case of self-neglect, by themselves, is required to report such knowledge or suspicion to the Florida Abuse Hotline.

By Phone : Call Florida Abuse Hotline at **1-800-96-ABUSE (1-800-962-2873).** Press 1 to report suspected abuse, neglect or exploitation of the elderly or a vulnerable adult. This toll free number is available 24/7.

TDD (Telephone Device for the Deaf) : 1-800-453-5145

By Fax: To make a report via fax, please send a detailed written report with your name and contact telephone to 1-800-914-0004.

To report online: Go to DCF Web site at
www.dcf.state.fl.us/programs/abuse/report.shtml

Failure to report known or suspected cases of abuse, neglect, or exploitation is a crime. Not reporting child abuse, neglect, or abandonment (or preventing someone else from reporting) is classified as a third degree felony in Florida. Someone convicted of a third degree felony can be required to serve up to five years in prison. Not reporting cases of abuse, neglect, or exploitation of adults with developmental disabilities (or preventing someone else from reporting) is classified as a second degree misdemeanor (which can result in you serving up to 60 days in jail).

If you are a service provider, failure to report known or suspected abuse can also cause you to lose your job and/or face possible legal action. When in doubt, report it; it is always better to m are a mistake on the side of caution. Reports should be made even if the incident happened a long time ago or took place in a school.

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727-447-2950 FAX

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 serves. Service, equipment, and billing complaints will be communicated to management and upper management. These 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 complaint, 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 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.

In the event we cannot resolve your issue, you can contact The Compliance Team at the following number 1-888-291-5353.

The patient will be informed of this complaint resolution protocol at the time of set-up of service.

Thank you,

Staff at Superior Prosthetics & Orthotics

Hours of Operation:
Monday - Friday 8:00am-5:00pm
Closed daily for Lunch 12:00-1:00
Closed Major Holidays
Extended Hours by APPOINTMENT ONLY