Ortho Pro
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OPA Inc.

PATIENT INFORMATION FORM

DATE: _____

Section 1 – Patient Information

Patient Name:_____ SSN:_____ Date of Birth:_____

Home Address:_____ City:_____ State:_____ Zip:_____

Email Address:_____

Home Tel #:_____ Work Tel #:_____ Mobile #:_____

Sex: Male / Female Marital Status: Single / Married / Other Height:_____ Weight:_____

Patient's Employer:_____

Employer's Address:_____ City:_____ State:_____ Zip:_____

Spouse's Name:_____ Work Tel #:_____ SSN:_____

Section 2 – Parent / Guardian / Responsible Party

Name (Last, First, MI):_____ SSN:_____ Date of Birth:_____

Relationship to Patient: Spouse / Parent / Guardian / Other (Explain) _____

Employer:_____ Tel #: _____

Employer's Address:_____ City:_____ State:_____ Zip:_____

Section 3 – Emergency Contact

Name (Last, First, MI):_____

Work Tel #:_____ Home Tel #:_____ Relationship:_____

Section 4 – Medical Information

Diagnosis:_____Date of injury:_____

How/Where did the injury occur: _____

Primary Care Physician:_____ Tel #:_____

Referring Physician/Referral Source:_____ Tel #:_____

Are You Diabetic? Y / N Physician Managing Diabetes:_____ Tel #:_____

If Amputation, Amputation Date:_____ Level of Amputation:_____ Amputation Side: R/ L /BIL

Section 5 – Insurance Information

Is this a Worker's Comp Claim? Y / N (if Yes, please complete WORKER'S COMP form)

Is this due to an Auto/Home accident? Y / N Date of Injury:_____ State that Accident Occurred in:_____

Primary Insurance: _____ Secondary Insurance: _____

Policyholder: _____ Policyholder: _____

Policyholder DOB: _____ Policyholder DOB: _____

Policyholder SSN: _____ Policyholder SSN: _____

Group #: _____ ID #: _____ Group #: _____ ID #: _____

Case Mgr: _____ Tel #: _____ Case Mgr: _____ Tel #: _____

Patient's Relationship to Policyholder: _____ Patient's Relationship to Policyholder: _____

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AUTHORIZATION FORM

INSURANCE AUTHORIZATION:

I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE TO THE ABOVE NAMED PROVIDER ON MY BEHALF, FOR ANY SERVICES PROVIDED TO ME. I AUTHORIZE ANY HOLDER OF MEDICAL AND OTHER INFORMATION ABOUT ME TO RELEASE TO MEDICARE AND ITS AGENTS, ANY INSURANCE COMPANY, ANY OTHER THIRD PARTY PAYER, STATE MEDICAL ASSISTANCE AGENCY, OR ANY OTHER GOVERNMENTAL OR PRIVATE PAYER RESPONSIBLE FOR PAYING SUCH BENEFITS, ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS FOR RELATED SERVICES. I AGREE TO PAY FOR ALL CHARGES NOT COVERED BY A THIRD PARTY PAYER. I AUTHORIZE A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.

ABOUT FINANCIAL ARRANGEMENTS AND MEDICAL INSURANCE

WE ARE COMMITTED TO PROVIDING YOU WITH THE BEST POSSIBLE CARE. IF YOU HAVE MEDICAL INSURANCE, WE ARE ANXIOUS TO HELP YOU RECEIVE YOUR MAXIMUM ALLOWABLE BENEFITS, IN ORDER TO ACHIEVE THESE GOALS, WE NEED YOUR UNDERSTANDING OF OUR PAYMENT POLICY. PAYMENT FOR SERVICES IS DUE AT THE TIME SERVICES ARE RENDERED. WE ACCEPT CASH, CHECKS, MASTERCARD, OR VISA. WE WILL BE HAPPY TO PROCESS YOUR INSURANCE CLAIM-FORM FOR REIMBURSEMENT. IN MOST INSTANCES WE ACCEPT ASSIGNMENT OF INSURANCE BENEFITS. RETURNED CHECKS AND BALANCES OLDER THAN 30 DAYS MAY BE SUBJECT TO ADDITIONAL COLLECTION FEES AND INTEREST CHARGES OF 1 ½% PER MONTH. WE WILL GLADLY DISCUSS YOUR PROPOSED TREATMENT AND ANSWER ANY QUESTIONS RELATING TO YOUR INSURANCE. YOU MUST REALIZE, HOWEVER, THAT:

1- YOUR INSURANCE IS A CONTRACT BETWEEN YOU, YOUR EMPLOYER AND THE INSURANCE COMPANY. WE ARE NOT A PARTY TO THAT CONTRACT.
2- OUR FEES ARE GENERALLY CONSIDERED TO FALL WITHIN THE ACCEPTABLE RANGE BY MOST COMPANIES, AND THEREFORE ARE COVERED UP TO THE MAXIMUM ALLOWANCE DETERMINED BY EACH CARRIER. THIS APPLIES ONLY TO COMPANIES WHO PAY A PERCENTAGE (SUCH AS 50%, OR 80%) OF USUAL AND CUSTOMARY RATES. THUS, OUR FEES ARE CONSIDERED USUAL, CUSTOMARY AND REASONABLE BY MOST COMPANIES. THIS STATEMENT DOES NOT APPLY TO COMPANIES WHO REIMBURSE BASED ON AN ARBITRARY "SCHEDULE" OF FEES, WHICH BEARS NO RELATIONSHIP TO THE CURRENT STANDARD AND COST OF CARE IN THIS AREA.
3- NOT ALL SERVICES ARE A COVERED BENEFIT IN ALL CONTRACTS. SOME INSURANCE COMPANIES ARBITRARILY SELECT CERTAIN SERVICES THEY WILL NOT COVER.

WE MUST EMPHASIZE THAT AS ORTHOTIC AND PROSTHETIC PROVIDERS, OUR RELATIONSHIP IS WITH YOU, NOT YOUR INSURANCE COMPANY. WHILE THE FILING OF INSURANCE CLAIMS IS A COURTESY THAT WE EXTEND TO OUR PATIENTS, ALL CHARGES ARE YOUR RESPONSIBILITY FROM THE DATE THE SERVICES ARE RENDERED. ANY DEDUCTIBLES AND /OR COINSURANCE PAYMENTS MUST BE PAID IN FULL BY THE FINAL FITTING AND COMPLETION OF THE ORTHOSIS OR PROSTHESIS. IF YOU HAVE ANY QUESTIONS ABOUT THE ABOVE INFORMATION OR ANY UNCERTAINTY REAGARADING INSURANCE COVERAGE, PLEASE DO NOT HEISTATE TO ASK US. WE ARE HERE TO HELP YOU.

PATIENT/LEGAL GUARDING SIGNATURE: _____

PATIENT NAME: _____ **DATE:** _____

***MEDICARE PATIENTS:**

I CERTIFY THAT I HAVE RECEIVED THE MEDICARE SUPPLIER STANDARDS_____

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PLEASE READ CAREFULLY!!

Medicare has specific guidelines with regard to supplying multiple orthotic/prosthetic devices to one patient. I many cases, the second same or similar device provided to a patient within a specific period of time, regardless of who supplied these devices, will be denied for payment as it may be deemed not medically necessary.

Due to the present guidelines in place by Medicare, it is important for us to be made aware of your previous orthotic/prosthetic device history. Generally, orthotic devices are designed to support a weak or injured body part and may include such items as back braces, supports, ankle supports or sleeves, corsets, CAM walkers or boots, etc. Prosthetics devices would include any artificial limbs designed to replace a missing arm or leg.

Please take a moment to consider your possible orthotic/prosthetic device history. This information is important for us to help you make informed decisions about any devices supplied to you now and what your financial responsibility may be.

1) Have you received an orthotic or prosthetic device within the previous five years? _____Yes _____No

2) If you have received an orthotic or prosthetic device within the previous five years, please supply us with the date to the best of your recollection and briefly describe the device received.

_____ _____
Date Item Received

_____ _____
Date Item Received

I have read the above information and understand it's content. I further understand that if I have received previous orthotic or prosthetic devices, Medicare may deny payment and I can be held financially responsible for items received.

_____ _____
Patient's Signature Date

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this Notice please contact: our Privacy Contact who is

Ana L. Estevez, HIPAA Compliance Officer, Contact Number: (305)598-9688

OUR COMMITMENT TO PROTECT YOUR HEALTH INFORMATION

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Your "protected health information" means any of your written and oral health information, including your demographic data that can be used to identify you. This is health information that is created or received by your health care provider, and that relates to your past, present or future physical or mental health or condition.

We are strongly committed to protecting your medical information. We create a medical record about your care because we need the record to provide you with appropriate treatment and to comply with various legal requirements. We transmit some medical information about your care in order to obtain payment for the services you receive, and we use certain information in our day to day operations. This Notice will let you know about the various ways we use and disclose your medical information, describe your rights and our obligations with respect to the use or disclosure of your medical information. We will also ask that you acknowledge receipt of this Notice the first time you come to or use any of our facilities, because the law requires us to make a good faith effort to obtain your acknowledgment.

We are required by law to:

Make sure that any medical or health information that we have that identifies you is kept private, and will be used or disclosed only in accord with this Notice of Privacy Practices and applicable law;

Give you this Notice of our legal duties and our privacy practices; and

Abide by the terms of the Notice of Privacy Practices that is in effect from time to time.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

A. Uses and Disclosures of Protected Health Information for Treatment, Payment and Healthcare Operations

Your protected health information may be used and disclosed by your **(Orthotist or Prosthetist)**, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of this Ortho Pro Associates, Inc..

Following are examples of the types of uses and disclosures of your protected health care information that this Ortho Pro Associates, Inc. is permitted to make. We have provided some examples of the types of each use or disclosure we may make, but not every use or disclosure in any of the following categories will be listed.

For Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related treatment. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to the physician that referred you to us. We will also disclose protected health information to other health care providers who may be treating you when we have the necessary permission from you to disclose your protected health information.

For Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. We may also tell your health plan about an orthotic or prosthetic device you are going to receive to obtain prior approval or to determine whether your plan will cover the device.

For Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of this Ortho Pro Associates, Inc.. These activities include, but are not limited to, quality assessment activities, employee review activities, legal services, licensing, and conducting or arranging for other business activities. We may share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for this Ortho Pro Associates, Inc.. Whenever an arrangement between our Ortho Pro Associates, Inc. and our business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

Treatment Alternatives: We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Appointment Reminders: We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

Sign In Sheets: We may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your **(Orthotist or Prosthetist)** is ready to see you.

Marketing and Health Related Benefits and Services: We may also use and disclose your protected health information for other marketing activities. For example, we may send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you.

Sale of the Practice: If we decide to sell this practice or merge or combine with another practice, we may share your protected health information with the new owners.

B. Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke your authorization, at any time, in writing. You understand that we can not take back any use or disclosure we may have made under the authorization before we received your written revocation, and that we are required to maintain a record of the medical care that has been provided to you. The authorization is a separate document, and you will have the opportunity to review any authorization before you sign it. We will not condition your treatment in any way on whether or not you sign any authorization.

C. Other Permitted and Required Uses and Disclosures That May Be Made Either With Your Agreement or the Opportunity to Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your **(Orthotist or Prosthetist)** may, using their professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, orally or in writing, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose your protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location or general condition.

D. Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to object.

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by federal, state or local law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. A disclosure under this exception would only be made to somebody in a position to help prevent the threat to public health

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse,

neglect or domestic violence to the governmental entity or agency authorized to receive such information. We will only make this disclosure if you agree or when required or authorized by law. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Military and Veterans: If you are a member of the military, we may release protected health information about you as required by military command authorities.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose your protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose your protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes might include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the Ortho Pro Associates, Inc.'s premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose your protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: Under certain circumstances, we may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs that provide benefits for work-related illnesses and injuries.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional Ortho Pro Associates, Inc. and your **(Orthotist or Prosthetist)** created or received your protected health information in the course of providing care to you.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the final rule on Standards for Privacy of Individually Identifiable Health Information.

2. YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of your protected health information contained in your medical and billing records and any other records that your **(Orthotist or Prosthetist)** uses for making decisions about you, for as long as we maintain the protected health information.

To inspect and copy your medical information, you must submit a written request to the Privacy Contact listed on the first and last pages of this Notice. If you request a copy of your information, we may charge you a fee for the costs of copying, mailing or other costs incurred by us in complying with your request.

We may deny your request in limited situations specified in the law. For example, you may not inspect or copy psychotherapy notes; or information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and certain other specified

protected health information defined by law. In some circumstances, you may have a right to have this decision reviewed. The person conducting the review will not be the person who initially denied your request. We will comply with the decision in any review. Please contact our Privacy Contact if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your (Orthotist or Prosthetist) is not required to agree to a restriction that you may request. If the **(Orthotist or Prosthetist)** believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your **(Orthotist or Prosthetist)** does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your **(Orthotist or Prosthetist)**. You may request a restriction by **contacting our HIPAA Compliance Officer**

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Contact.

You may have the right to have your (Orthotist or Prosthetist) amend your protected health information. This means you may request an amendment of your protected health information contained in your medical and billing records and any other records that your **(Orthotist or Prosthetist)** uses for making decisions about you, for as long as we maintain the protected health information. You must make your request for amendment in writing to our Privacy Contact, and provide the reason or reasons that support your request.

We may deny any request that is not in writing or does not state a reason supporting the request. We may deny your request for an amendment of any information that:

1. Was not created by us, unless the person that created the information is no longer available to amend the information;
2. Is not part of the protected health information kept by or for us;
3. Is not part of the information you would be permitted to inspect or copy; or
4. Is accurate and complete.

If we deny your request for amendment, we will do so in writing and explain the basis for the denial. You have the right to file a written statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Contact to determine if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right only applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It also excludes disclosures we may have made to you, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations. You must submit a written request for disclosures in writing to the Privacy Contact. You must specify a time period, which may not be longer than six years and cannot include any date before April 14, 2003. You may request a shorter timeframe. Your request should indicate the form in which you want the list (i.e., on paper, etc). You have the right to one free request within any 12 month period, but we may charge you for any additional requests in the same 12 month period. We will notify you about the charges you will be required to pay, and you are free to withdraw or modify your request in writing before any charges are incurred.

You have the right to obtain a paper copy of this notice from us, upon request to our Privacy Contact, or in person at our office, at any time, even if you have agreed to accept this notice electronically. [You may obtain a copy of this notice at our website, www.orthoproassociates.com.]

3. COMPLAINTS: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you in any way for filing a complaint, either with us or with the Secretary.

You may contact our Privacy Contact, **Ana L.Estevez** at (305)598-9688 or **info@orthoproassociates.com** for further information about the complaint process.

4. CHANGES TO THIS NOTICE: We reserve the right to change the privacy practices that are described in this Notice of Privacy Practices. We also reserve the right to apply these changes retroactively to Protected Health Information received before the change in privacy practices. You may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, asking for one at the time of your next appointment, or accessing our website

This notice was published and becomes effective on **April 14, 2012**

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Acknowledgement of Receipt of Notice of Privacy Practices

I certify that I have received a copy of **ORTHO PRO ASSOCIATES, INC.'s** Notice of Privacy Practices. The Notice of Privacy Practices 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 **ORTHO PRO ASSOCIATES, INC.'s** health care operations. The Notice of Privacy Practices also describes my rights and **ORTHO PRO ASSOCIATES, INC.'s** duties with respect to my protected health information. The Notice of Privacy Practices is posted in **the facilities waiting room.**

ORTHO PRO ASSOCIATES, INC. 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 and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority