BT Orthotic Labs Patient Registration

PERSONAL	First: _____ MI:_____ Last: _____ Sex: Male _____ DOB: _____ SSN: _____
CONTACT	Address: _____ City: _____ State: _____ Zip: _____ Primary Phone: _____ Type: Mobile _____ Secondary Phone:_____ Type: Mobile _____ Email: _____
EMERGENCY CONTACT	Name: _____ Relationship: _____ Phone: _____
GUARANTOR	Name: _____ Relationship: _____ Phone: _____ Address: _____ City: _____ State: _____ Zip: _____
PHYSICIAN	Referring: _____ Phone: _____ Primary: _____ Phone: _____

CONDITION	Are you familiar with the device prescribed and its purpose? Yes No Have you received a similar service in the past five years? Yes No Are you in hospice care? Yes No Are you a resident of a skilled nursing facility? Yes No Are you a diabetic? Yes No Treating Physician: _____ Phone: _____
PRIMARY INSURANCE	Insurer: _____ Name of Insured: _____ Relationship: _____ DOB: _____
SECONDARY INSURANCE	Insurer: _____ Name of Insured: _____ Relationship: _____ DOB: _____
Please present the receptionist with your insurance card(s) so we may make copies.	

I certify that the information provided by me is true, accurate and complete.

_____ _____

Signature of Patient/Guarantor **Date**

BT ORTHOTIC LABS, INC.

Payment Agreement

I understand that some insurance policies do not fully cover all charges. I agree that I will assume responsibility for any approved co-insurance and / or deductible amount for covered procedures and full charges for any uncovered procedures. We do not accept assignment for custom foot orthoses. **PRIOR TO FABRICATION, PAYMENT IN FULL IS REQUIRED FOR ALL CUSTOM FOOT ORTHOSES.** There are **NO REFUNDS** on custom devices.

Treatment Consent

By signing below, I hereby consent to having BT Orthotic Labs, Inc., and its employees, provide Orthotic service to me / my dependent. I consent to authorize them to take any and all measurements, casting, molding, photographs, tracing, etc. as necessary to design fabricate, fit and deliver the prescribed device(s).

Warranty Policy

BT Orthotic Labs, Inc. offers a 60 day warranty on parts, components and workmanship. This warranty covers any adjustments, alterations, repairs or replacement that may be necessary due to normal wear and tear. BT Orthotic Labs, Inc. may decide to alter, adjust, repair or replace an orthosis at their discretion. Warranty does not cover repairs, adjustment, alterations or modifications that may be necessary as a result of neglect, abuse, anatomical changes in the prescription or its components.

Signature: _____ Date: _____

BT Orthotic Labs, Inc.

Assignment of Benefits/ Authorization to Release Information

I request that payment of authorized Medicare, Medicaid, or private insurance benefits be made to BT Orthotic Labs, Inc. for any covered services furnished by BT Orthotic Labs, Inc. I agree to pay to BT Orthotic Labs, Inc. the deductible and / or coinsurance on my claim.

I authorize any holder of medical information about me to release to the centers for Medicare & Medicaid Services (CMS) and its agents, or to any private insurance company to determine these benefits or the benefits payable for related services that need information.

I further certify that the information provided by me is true, accurate and complete.

I understand and agree that I am responsible for the following expenses: any service my insurance plan deems "non-covered", all coinsurance and / or co-payment amounts, all deductibles, any amount that exceeds benefit limits under my insurance plan and any amount my insurance plan deems not covered because I was not insured on that date of service.

I acknowledge having received 1) a copy of BT Orthotic Labs, Inc. Notice of Privacy Practices (NPP) 2) Patient Medicare DMEPOS Supplier Standards, Bill of Rights, Warranty & Patient Responsibilities and 3) BT Orthotic Labs, Inc.'s Financial Policy.

Patient or Responsible Party Signature _____ Date_____

If Responsible Party, please complete below:

Printed Name _____

Address_____

Relationship to Patient: _____

Reason for Patient's Inability to Sign: _____

For Notice of Privacy Practices only, describe the Responsible Party's authority to act on behalf of the patient: _____

Form Effective Date: 9/2020

NOTICE OF PRIVACY PRACTICES
For BT ORTHOTIC LABS, INC.

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: *Melissa Irizarry* our Privacy Officer at (631) 470- 3778.

Our Commitment to Protecting Your Health Information

This Notice of Privacy Practice describes how we may use and disclose your Protected Health Information ("PHI") 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 PHI. Your "protected health information" means any of your written or oral health information, including 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 PHI. 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 of 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 and 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 acknowledgement.

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 Practice that is in effect from time to time.

Summary of

NOTICE OF PRIVACY PRACTICE

BT ORTHOTIC LABS, INC.

This Summary briefly describes important information contained in our Notice of Privacy Practices. We encourage you to take the time to read the complete Notice, which is attached to this summary.

Our Notice of Privacy Practice 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.

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:

1. 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 our Notice of Privacy and applicable law;
2. Give you the complete Notice of our legal duties and our privacy practices; and
3. Abide by the term of the Notice of Privacy Practice that is in effect from time to time.

Financial Policy

Thank you for choosing BT Orthotic Labs, Inc. We are committed to the success of your care. Please understand that payment of your bill is part of this treatment and care. The following information is provided as a courtesy to clarify your financial responsibility related to professional services provided by BT Orthotic Labs, Inc. This document does not cover all situations and should not be an all-inclusive listing of all possible situations. If a specific payer (Worker's Comp) contract is in conflict with any of the policies below, then the payer contract will supersede the conflicting policies. As a part of our commitment of service to you, we will make every attempt to verify your insurance benefits at the time your services are rendered. However, insurance verification or authorization is not a guarantee of insurance payment. This only allows our office to provide you with a preliminary estimate of any monies due by the insured at the time of delivery of the device. Your patient portion is subject to change based on final claim determination by your insurance carrier.

What Is My Financial Responsibility For Services? Your financial responsibility depends on a variety of factors, explained below.

If You Have….	**You Are Responsible For…**	**Our Staff Will…**
Insurance Plan with whom we have a contract	<u>If the service you receive are covered by the plan</u>: Patient Portion (co-pays, deductibles, co-insurance, etc.) on or before Date of delivery <u>If the services you receive are not covered by the plan</u>: Payment in full on or before date of delivery.	Contact your insurance plan to obtain your eligibility, benefit information and patient portion (co-pays, deductibles, Co-insurance, Etc. Submit your insurance claim.
Insurance plan with whom we are Not Contracted or we are NOT an "In-Network" Provider.	Payment in full on or before date of delivery, unless your plan agrees to pay us directly.	Contact your insurance plan to obtain your eligibility and Out-of-Network benefit information. Submit your insurance claim if your plan agrees to pay us directly.
Medicare Part B	<u>If you have Medicare Part B</u>, and have not met your deductible, we ask that it be paid on or before date of delivery. <u>If you do not have secondary insurance</u>, Medicare co-insurance amount on or before date of delivery. <u>If the total services are less than $250</u>, full payment on or before date of delivery. <u>Payment for any services not covered by Medicare</u> on or before date of delivery.	Contact Medicare and second insurance Plan (if applicable) to obtain your eligibility and benefit information.

Financial Policy

		Submit your insurance claim to Medicare, as well as any claims to your secondary insurance.
No Insurance	Payment in full due on or before date of delivery.	Advise you regarding charges for service Provided.

How May I Pay? We accept payment by: Cash, Check, Credit Card. NOTE: Charges not covered by your insurance plan, as well as applicable co-payments and deductible, are your responsibility.

Effective date: 07/29/2020

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.
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. A supplier must have an authorized individual (whose signature is binding) sign the enrollment application for billing privileges.
4. A supplier must fill orders from its own inventory, or contract with other companies for the purchase of items necessary to fill orders. A supplier may not contract with any entity that is currently excluded from the Medicare program, any State health care programs, or 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 and must maintain a visible sign with posted hours of operation. The location must be accessible to the public and staffed during posted hours of business. 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 is prohibited from direct solicitation to Medicare beneficiaries. For complete details on this prohibition see 42 CFR § 424.57 (c) (11).
12. A supplier is responsible for delivery of and must instruct beneficiaries on the use of Medicare covered items, and maintain proof of delivery and beneficiary instruction.
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 cost either directly~~,~~ or through a service contract with another company, any 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 standards to each beneficiary it supplies a Medicare-covered item.
17. A supplier must disclose 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 regulations.
22. All supplier~~s~~ 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 for those specific products and services (except for certain exempt pharmaceuticals).
23. All supplier~~s~~ 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 supplier~~s~~ must disclose upon enrollment all products and services, including the addition of new product lines for which they are seeking accreditation.
26. A supplier must meet the surety bond requirements specified in 42 CFR § 424.57 (d).
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 CFR § 424.516(f).
29. A supplier is prohibited from sharing a practice location with other Medicare providers and suppliers.
30. A supplier-must remain open to the public for a minimum of 30 hours per week except physicians (as defined in section 1848(j) (3) of the Act) or physical and occupational therapists or a DMEPOS supplier working with custom made orthotics and prosthetics.

MEDICARE DMEPOS SUPPLIER STANDARDS

DMEPOS suppliers have the option to disclose the following statement to satisfy the requirement outlined in Supplier Standard 16 in lieu of providing a copy of the standards to the beneficiary.

The products and/or services provided to you by (supplier legal business name or DBA) are subject to the supplier standards contained in the Federal regulations shown at 42 Code of Federal Regulations Section 424.57(c). These standards concern business professional and operational matters (e.g. honoring warranties and hours of operation). The full text of these standards can be obtained at http://www.ecfr.gov. Upon request we will furnish you a written copy of the standards.