PATIENT INFORMATION

NAME ______________________________

ADDRESS ______________________________

CITY ______________________________

STATE ____________ ZIP ______________

HOME PHONE ______________________________

WORK PHONE ______________________________

CELL PHONE ______________________________

BIRTH DATE ________________ AGE ______

☐ MALE ☐ FEMALE

SOCIAL SECURITY # ______________________

EMAIL ADDRESS ______________________

REFERRING PHYSICIAN ______________________

PRIMARY PHYSICIAN ______________________

PARENT/LEGAL GUARDIAN

NAME ______________________________

ADDRESS ______________________________

CITY ______________________________

STATE ____________ ZIP ______________

PHONE # ______________________________

PAYMENT RESPONSIBILITY

COMPLETE IF DIFFERENT FROM ABOVE

NAME ______________________________

ADDRESS ______________________________

CITY ______________________________

STATE ____________ ZIP ______________

PHONE # ______________________________

BIRTHDATE ______________SS# ____________

RELATIONSHIP TO PATIENT ________________

*****LATEX ALLERGY? ☐ YES ☐ NO**

INSURANCE INFORMATION

COMPANY ______________________________

ID#_______________ GROUP# ______________

POLICY HOLDER ______________________

DOB______________ SS# ______________

RELATIONSHIP TO PATIENT ________________

SECONDARY INSURANCE

COMPANY ______________________________

ID#_______________ GROUP# ______________

POLICY HOLDER ______________________

DOB______________ SS# ______________

RELATIONSHIP TO PATIENT ________________

_____WORK COMP _____AUTO ACCIDENT

DATE OF ACCIDENT______________________

INSURANCE COMPANY ______________________

CLAIM# ______________________________

CONTACT ______________________________

PLEASE READ, SIGN, AND DATE

If patient is unable to sign, please indicate

REASON ______________________________

SIGNERS AUTHORITY/RELATIONSHIP ________________

Great Steps Orthotic & Prosthetic Solutions agrees to bill most insurance carriers, if all necessary information is provided.

I, the patient or legal representative, agree to be financially responsible for all charges whether or not paid for by insurance.
I assign to Great Steps Orthotic & Prosthetic Solutions, permission to bill my insurance company and release information pertaining to claim submittal.
I acknowledge receipt or offer of the main patient intake brochure which includes: **MEDICARE SUPPLIER STANDARDS / NOTICE OF PRIVACY PRACTICES / WARRANTY / and BILL OF RIGHTS**

SIGNATURE ______________________________

DATE SIGNED ______________________________

Patient Name: ___________________________________

Acknowledgement of Receipt of Medicare Supplier Standards

Great Steps Orthotic & Prosthetic Solutions agrees to bill most insurance carriers, if all necessary information is provided.

I, the patient or legal representative, agree to be financially responsible for all charges whether or not paid for by insurance.
I assign to Great Steps Orthotic & Prosthetic Solutions, permission to bill my insurance company and release information pertaining to claim submittal.
I acknowledge receipt or offer of the main patient intake brochure which includes: **MEDICARE SUPPLIER STANDARDS / NOTICE OF PRIVACY PRACTICES / WARRANTY / and BILL OF RIGHTS**

SIGNATURE ___________________________________

DATE SIGNED ___________________________________

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Acknowledgement of Receipt of Notice of Privacy Practices

Effective Date: April 14, 2003; Updated Date: September 17, 2013

I certify that I have received or been offered a copy of 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 Great Steps O&P's health care operations. The Notice of Privacy Practices also describes my rights and Great Steps O&P's duties with respect to my protected health information. The Notice of Privacy Practices is posted in all Great Steps O&P facilities.

Great Steps O&P 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.

_____ No Restrictions **______ I object to the following disclosures:**

____
Please describe disclosure objections

_______________________________________ _______________________________________
Signature of Patient or Personal Representative Date

If Representative, please complete below

____
Print Representative Name Explain Relationship to Patient

____
Reason for Patient's Inability to Sign

~~~~~~
(This area for Great Steps Personnel)

______ Restriction Accepted ______ Restriction Denied

Reason:____

____
Great Steps Staff Signature Title Date

Great Steps O&P – St. Cloud
154 19 Street South, Suite 1
Sartell, MN 56377
320-229-1742
866-229-1742

Great Steps O&P – Business Centre
P.O. Box 437
Cold Spring, MN 56320
320-229-1742
866-229-1742

CMS Medicare DMEPOS
Supplier Standards

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. 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. The supplier location must be accessible to beneficiaries during reasonable business hours, and must maintain a visible sign and posted hours of operation.
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.

HIPAA Privacy Rule

The *Standards for Privacy of Individually Identifiable Health Information* ("Privacy Rule") establishes, for the first time, a set of national standards for the protection of certain health information. The U.S. Department of Health and Human Services ("HHS") issued the Privacy Rule to implement the requirement of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The Privacy Rule standards address the use and disclosure of individuals' health information – called "protected health information" by organizations subject to the Privacy Rule – called "covered entities", as well as standards for individuals' privacy rights to understand and control how their health information is used. Within HHS, the Office for Civil Rights ("OCR") has responsibility for implementing and enforcing the Privacy Rule with respect to voluntary compliance activities and civil money penalties.

A major goal of the Privacy Rule is to assure that individuals' health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well being. The Rule strikes a balance that permits important uses of information, while protecting the privacy of people who seek care and healing. Given that the health care marketplace is diverse, the Rule is designed to be flexible and comprehensive to cover the variety of uses and disclosures that need to be addressed.

For more information, please refer to the HIPAA folder in the lobby. If you would like a copy of the information that is in the HIPAA folder, please ask the receptionist. If you have any questions, comments, concerns, or complaints, please contact Great Steps O&P at 320-229-1742.

Patient Responsibilities

Keep all appointments when possible

Inform Great Steps O&P of any change in your overall health which may affect the wearing or functioning of the orthosis or prosthesis.

Within thirty (30) days after the item is delivered, inform Great Steps O&P if any adjustments are necessary. Failure to do so will constitute a waiver by the patient of any claim regarding said item

Patient Financial Responsibilities

Great Steps O&P agrees to bill most insurance carriers if all necessary information is provided.

Patient or legal representative agrees to be financially responsible for all charges whether or not paid by insurance.
Patient assigns to Great Steps O&P, permission to bill his/her insurance company and release information pertaining to claim submittal.

Bill of Rights

It is the policy of Great Steps O&P to recognize that individuals seeking services have the same rights as other individuals in our society. Among these are:

1. The right to secure appropriate prosthetic and orthotic services regardless of race, religion, color, ethnicity, sex, age, handicap, marital status or sexual preference.

2. The right to a humane service environment which affords appropriate privacy.

3. The right to receive adequate and appropriate services in a safe and clean environment, from the appropriate individual within the facility, information about his/her prosthetic and orthotic care, in terms the patient can understand.

4. The right to participate fully in all decisions concerning their health, well being and rehabilitation.

5. The right to refuse services to the extent provided by law and to be informed of the consequences of the refusal. When a refusal of services prevents the facility or its staff from providing appropriate care according to ethical and professional standards, the relationship with the patient may be terminated upon reasonable notice.

6. The right to exercise his/her rights as a patient and as a citizen, and to this end present grievances or recommend changes to policies and services on behalf of himself/herself or others to the facility staff, to governmental officials or to another person of his/her choice within or outside the facility, free from restraint, interference, coercion, discrimination or reprisal. A patient is entitled to information about the facility's policies and procedures regarding the initiation, review and resolution of patient complaints.

7. Examine and receive a full explanation of the facility bill regardless of the source of payment. Every patient is informed of the mechanism within the facility to resolve billing questions or problems.

8. Be informed of facility rules and regulations applicable to a patient's conduct. Every patient is informed of the mechanisms within the facility available to resolve problems or conflicts.

Warranty

Your custom fabricated prosthetic/orthotic device is warranted for 90 days to provide proper alignment and proper fit, corresponding with your individual measurements and anatomical conditions at the time of measurement. Your custom fit prosthetic/orthotic device/item is warranted for 60 days to be of the appropriate size and fit at the time of delivery. Once a device is delivered, it is not eligible for a money-back warranty due to the health risks involved in the reuse of prosthetic/orthotic devices.

This warranty does not apply to items or parts that are not manufactured by Great Steps. Items and parts that are manufactured by outside companies or vendors are warranted for the length of the warranty determined by that manufacturer. These include, but are not limited to: components or parts not manufactured by Great Steps that are used in the assembly of a device custom made by Great Steps; items that are custom made by other companies but supplied to the patient by Great Steps, or items that are manufactured by other companies, but are fit or custom fit to the patient by Great Steps.

This warranty is immediately void if:

- The device has been adjusted, repaired or altered by anyone other than an active employee of Great Steps.
- The device or any of its parts have been subjected to misuse, negligence or accident
- The patient fails to fulfill "Patient Responsibilities" as outlined below.

This warranty does not cover prosthetic skin coverings, adjustments needed due to anatomical or other medical changes, nor does it cover accessories, such as prosthetic socks, straps, etc.

Any claim whatsoever made by a recipient patient in connection with a prosthetic or orthotic device covered under this warranty shall be limited to the amount received by Great Steps from the patient for the subject device. Any claim whatsoever made by a reimbursing source/payer in connection with a prosthetic or orthotics device covered under this warranty shall be limited to the amount received by Great Steps from such reimbursing source/payer for the subject device.

Great Steps Orthotics & Prosthetics
154 19th Street South, Sartell, MN 56377 (320) 229-1742

Patient's Name: ___________________________ Date of Birth: _____________ Chart ID: ______________
(Office will complete chart ID)

I. Consent and Authorization for Release of Information

1) Release of Information. I consent to the release and use by Great Steps Orthotics & Prosthetics (referred to as "GSOP") of medical and *other* information about me to the extent permitted by law to the following
   a. To a health care provider being advised or consulted in connection with my treatment or care;
   b. To a health plan, insurer, third party payer, third party administrator or other organization providing me with health benefits, for the purposes of claims payment and benefit determinations, fraud investigations, or quality of care studies or reviews; and
   c. To a person or organization in connection with GSOP's health care operations. These operations may include interdisciplinary care conferences, quality improvement activities, performance evaluations, business management and other related activities.
   d. To the following individual(s):
      i. Spouse: ____Phone: ____________________
      ii. Family Members: ________________________________Phone: ____________________
      iii. Coach/Trainer/Employer: __________________________Phone: ____________________
      iv. Other: ____Phone: ___________________
   e. If we need to leave a voice message, what info may be disclosed on the numbers you provided?

☐ Medical/Treatment ☐ Financial/Billing ☐ Other: ______________________________

2) Revocation. I understand that this consent shall continue until I revoke it, which I may do at any time by giving written notice to GSOP.

3) By signing this consent form, you are agreeing that GSOP can request and use your prescription medication history from other healthcare providers and/or benefit payers for treatment purposes.

II. Notice of Privacy Practices

1) Confidentiality. It is the policy of GSOP to protect the privacy and confidentiality of patients' medical information.

2) Notice of Privacy Practice. GSOP's Notice of Privacy Practices explains how GSOP may use and disclose my medical information. It also explains my rights regarding this kind of information. GSOP may revise its Notice of Privacy Practices at any time and will provide me with a copy of the revised Notice of Privacy Practices at my request. GSOP's Notice of Privacy Practices is available at the Reception Desk.

3) Acknowledgement of Receipt. I acknowledge that I have received or have been offered GSOP's Notice of Privacy Practices.

Signature of Patient (if applicable): ____Date: ________________

Signature of Legal Guardian (if applicable): ___________________________________Date: _________________