Welcome! We look forward to seeing you at your appointment.

In order to expedite your visit, we request that you complete your paperwork before your appointment.

This Patient Packet consists of:

- ⇒ This page of Instructions
- ⇒ Patient Intake form, 2 pages
- ⇒ Injury Detail form (optional), 1 page
- ⇒ Summary Notice of Privacy Practices, 1 page
- ⇒ Medicare Supplier Standards, 2 pages (Medicare patients only)

Please enter all your information on the Patient Intake PDF form (2 pages), print and initial and sign on second page where indicated.

If you are being treated for a Worker's Comp or Motor Vehicle Injury, please complete the Injury Detail PDF form, print and sign where indicated.

You may bring the completed forms with you to your appointment or fax them to the clinic.

Clinic fax numbers can be found on our website www.bostonoandp.com, under "Our Clinics".

In order to maintain your patient privacy, please do not email completed forms.

boston ORTHOTICS & PROSTHETICS

Patient Intake Form

Patient ID: _____

Patient Information:

Patient's Last Name: _____First: _____Middle:_____

Legal Gender: M☑ F☐ Date of Birth: _____/_____/_____ Height: _____ Weight: _____

Mailing Address: _____ Apt #_____

City: _____ State: _____Zip Code: _____-_____

Home Phone #: _____ Mobile Phone #:_____Alternate Phone #:_____

Use this as primary phone ☐ Use this as primary phone ☐ Use this as primary phone ☐

☐ **Consent to Call**: *Boston O & P is permitted to call and or leave messages on the Mobile Phone # above*

☐ **Consent to Text**: *Boston O & P is permitted to send text message appointment reminders to the Mobile Phone # above*

Email Address: _____

(Your Email Address will be kept confidential and will only be used to contact you for a patient satisfaction survey or staff correspondence)

Referring Physician: _____ _____Phone # (if known)_____

Primary Care Physician: _____ _____Phone # (if known)_____

Is the patient involved in any of the following programs? (select all that apply)

Early Intervention Agency Name: _____ Therapist: _____ Phone #: _____

Physical Therapy Agency Name: _____ Therapist: _____ Phone #: _____

Occupational Therapy Agency Name: _____ Therapist: _____ Phone #: _____

Specialty School/Program Name: _____ Contact: _____ Phone #: _____

Guarantor Information: *(Person Who is Financially Responsible for this Patient)*

Patient's Relationship to Guarantor: _____

Name *(first/last):* _____ Date of Birth:_____/_____/_____

Address: *(If different)* _____

Insurance Information:

Is This Visit Related to a Worker's Comp or Motor Vehicle Injury? **Yes ☐ No ☐** **If Yes, please request & complete the Injury detail form.**

Primary Insurance Company: _____ **Policy Id #**: _____

Policy Holder's Name: _____ Date of Birth:_____/_____/_____

Relationship to Patient: _____

Secondary Insurance Company: _____ **Policy Id #**: _____

Policy Holder's Name: _____ Date of Birth:_____/_____/_____

Relationship to Patient: _____

Please continue to next page.

Patient Intake Form

Patient ID: _____

PLEASE READ EACH OF THESE STATEMENTS THOROUGHLY AND SIGN BELOW.
SIGNING BELOW IS ACKNOWLEDGEMENT THAT YOU HAVE
READ, UNDERSTAND AND AGREE TO EACH STATEMENT.

1. Benefits, Medical Information Release Authorization and Acknowledgement of Financial Responsibility
   The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Boston Orthotics & Prosthetics. I understand that I am financially responsible for any balance. I authorize the release of any information necessary to provide services or process claims.

2. Acknowledgement of Receipt of Notice of Privacy Practices
   I certify that I have received a summary copy of the Boston Brace International, Inc. /dba Boston O & P's Notice of Privacy Practices. A full copy is available at this office or online at www.bostonoandp.com.

3. Acknowledgement of Medicare DMEPOS Supplier Standards **(for Medicare patients only)**
   The products and/or services supplied to you by Boston Brace International, Inc. /dba Boston O & P are subject to the supplier standards contained in the Federal regulations. The full text of these standards can be obtained at http://www.ecfr.gov. Upon request, we will provide you with a written copy of the standards.

4. Acknowledgement of Boston O & P Payment and Refund Policies
   For custom items, full payment of coinsurance and deductible is required before the device is ordered or fabricated.
   For prefabricated items that are in stock, full payment of coinsurance and deductible is due at fitting.
   Items provided are non-returnable and non-refundable once you leave the office.
   We will make sure that you are satisfied and comfortable with the device before you leave. Any adjustments will be made free of charge.

5. Acknowledgement of Boston O & P Financial Policies
   - ⇒ Unpaid balances for prior services are due before you can receive new services.
   - ⇒ It is the patient/guardian's responsibility to be sure that all information for primary and secondary insurance is up to date and correct for every appointment. Failure to submit this information will result in being financially responsible for all services rendered.
   - ⇒ We will call your insurance company to verify benefits, coinsurance and deductible and provide you with an estimate for services. Benefits quoted by your insurance company are not a guarantee of payment. You will have the opportunity to approve the estimate before the device is ordered. Payment for coinsurance and deductible will be requested when you approve the estimate. While we make every attempt to provide you with an accurate estimate, it's only an estimate until your insurance company processes the claim.
   - ⇒ Your insurance company may require us to obtain an authorization to provide services. This may delay the delivery of your device since we cannot order or fit without the insurance authorization.
   - ⇒ If we request authorization for Out of Network (OON) benefits with your insurance provider, we do not accept the payer's rate for those services. You will be responsible for the reasonable and customary charges for the device.
   - ⇒ We bill your insurance company when you receive your device. Please keep this in mind if you are changing plans or your plan's renewal date is coming up; your estimate for coinsurance and deductible may change.
   - ⇒ If you are a Workers' Compensation patient, it's your responsibility to provide us with the information to process your claim. You can be held responsible for charges in the event that your claim is controverted.
   - ⇒ Returned checks will be subject to a $35 fee. Unpaid balances may be subject to collection placement and collection fees.

Signature of Patient or Personal Representative **Date**

Printed Name of Patient or Personal Representative

Description of Relationship to Patient (Self, Parent, Spouse, Sibling, Guardian, Friend, Caregiver, etc)

_____Notice given to patient; no parent/guardian available to sign

Summary Notice of Privacy Practices
Your Information. Your Rights. Our Responsibilities.

This summary 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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- 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

Please see page 1 of full privacy notice for more information on these rights and how to exercise them.

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Market our services and sell your information

Please see page 2 of the full privacy notice for more information on these choices and how to exercise them.

Our Uses and Disclosures

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
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Please see pages 2 and 3 of the full privacy notice for more information on these uses and disclosures.

Full privacy notice is available in any office or on our website, www.bostonoandp.com

Injury Detail Form

Worker's Comp & Auto Injury

Patient ID: _____

Last Name: _____First:_____ Middle:_____ Date of Birth: ____/____/_____
Employer (WC Only): _____ Policy #: _____

Claim #: _____Date of Injury: _____/_____/_____

Worker's Comp/Auto Insurance Company: _____

Phone #: _____Contact Person/Adjuster: _____

Please provide information about your injury:

Place where accident happened: _____

State where accident happened: _____

Injured Body Part: _____

Description of Accident:

Nature of Injury:

Benefits, Medical Information Release Authorization and Acknowledgement of Financial Responsibility:

I request my insurance benefits, if any, be paid directly to the provider. I authorize the release of any information necessary to provide services or process claims. As the responsible party, I understand that I am personally responsible for the entire amount of my claim and that insurance benefits may be limited or non-existent. I will assume the responsibility for any approved copayment and/or deductible amounts for covered procedures and the full charge for non-covered or denied procedures. I agree to notify Boston O & P immediately of any changes in insurance coverage or status.

_____

Signature of Patient or Personal Representative Date

_____

Printed Name of Patient or Personal Representative

_____

Description of Relationship to Patient (Self, Parent, Spouse, Sibling, Guardian, Friend, Caregiver, etc)

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://ecfr.gpoaccess.gov. Upon request we will furnish you a written copy of the standards.