WELCOME

Our staff and technical personnel operate as a team. We take great pride in our training, knowledge and capabilities, and we want you to know that we are dedicated to providing quality health care.

OFFICE HOURS

Regular office hours are 8:00am to 5:00pm Monday through Thursday, 8:00 to 2:00 on Friday, by appointment. We strongly believe in the value of your time and we will do our best to keep you from waiting. We appreciate 24 hours notice if you need to change your appointment.

TELEPHONE CALLS

Our administrative staff tends to all incoming calls. This allows practitioners to attend to their scheduled patients with a minimum of interruptions. If you should find it necessary to contact a practitioner after the hours designated above, you can call the designated on call staff at the phone number given on our regular phone line after hours. The on-call staff will be glad to answer your questions.

FEES AND PAYMENT

We make every effort to keep the cost of your medical care reasonable. You can help by paying any deductibles and coinsurance due at the time of your visit. This is expected unless other financial arrangements have been made. For your convenience, we accept all major credit cards, checks, and cash.

INSURANCE

If you have health insurance, please note that this is an agreement between you and your carrier. You are responsible for the payment of your bill regardless of the type of coverage you have. we help you at no charge in submitting your claims to your insurance for prompt reimbursement.

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The best health care is based on a friendly and mutual understanding among staff, practitioner and patient. If any problems or questions arise, do not hesitate to bring them to our attention immediately.

Again, thank you very much for calling this office. We are looking forward to providing “the difference” in prosthetic/orthotic services for you.

Date: _____ Referral person if called in: _____

Order taken by: _____ Phone: _____

BENEFICIARY INFORMATION Social Security Number: _____

Patient Name: _____ Date of Birth: _____

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

Phone: _____ Cell Phone: _____ Email address: _____

Gender: __ Male __ Female Marital Status: S__ M__ W__ D__ Height: _____ Weight: _____

Emergency Contact Name: _____ Telephone Number: _____

Relationship to Patient: _____ May we release PHI to this person? Yes___ No___

ORDERING/REFERRING & PRIMARY CARE PHYSICIAN INFORMATION

Ordering Physician Name: _____ Phone: _____

Primary Care Physician Name: _____ Phone: _____

QUESTIONS FOR THE PATIENT

Reason for your visit: _____

Side of body: Right ____ Left____ Shoe size: _____ Are you diabetic? Yes____ No____

Do you have any medical condition that we should consider or that may affect the care we provide you?

Yes____ No____ If yes, please explain: _____

Have you ever received a wheelchair or scooter? Yes____ No____ Date received (if yes): _____

INSURANCE INFORMATION

Please present the receptionist with your insurance card(s) and a photo ID so we may make copies for our records.

If you are **not** the primary insurance cardholder, please complete this section.

Name of Primary Cardholder: _____

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

Phone: _____ Work Phone: _____ SSN: _____ Date of birth: _____

Relationship to patient: _____

Primary Insurance

Carrier: _____ Policy Number: _____ Effective Date: _____

Secondary Insurance

Carrier: _____ Policy Number: _____ Effective Date: _____

Workman's Compensation Information

Carrier: _____ Claim Number: _____ Accident Date: _____

Adjuster's Name _____ Phone: _____ Employer's Name: _____

I request that the payment of authorized insurance benefits be made to Florida O&P Services, Inc., for any services they provide me. I authorize any holder of medical or other information about me lo release to the insurance payer or any of itl agents any information needed to determine payment of these benefits or benefits for related services.

I understand Florida O&P Services, Inc, will verify my insurance benefits if they are provided with the proper information. I further understand that when my insurance company is contacted they "quote" benefits, but that quote is not a guarantee of payment and determination of benefits can only be made once Florida O&P Services, Inc. submits a claim to my Insurance company.

I agree to be responsible for payment of any amounts not covered by my insurance carrier or any amounts remaining after rny insurance plan has made the payment, including all deductibles, copayments and coinsurance.

Signature of Patient or Responsible Party: _____ Date: _____

FLORIDA O&P SERVICES, INC.

ASSIGNMENT OF BENEFITS

The undersigned requests and understands that payment of insurance benefits be made on the customer's behalf to Florida O&P Services, lnc. for any services furnished.

MEDICAL INFORMATION RELEASE AUTHORIZATION GIVEN

The undersigned authorizes any holder of medical information about the customer to be released to Florida O&P Services, lnc. or its agents any information needed to determine benefits or the benefits payable for related services The undersigned understands that his/her signature authorizes release of medical information necessary to pay the claim.

FINANCIAL RESPONSIBILITY CONSENT

The undersigned agrees to assume financial responsibility for any claim or portion of claim thereof, due Florida O&P Services, Inc. for services provided not covered by the insurance policy as of the date listed below. If the insurance company denies coverage for a product, the undersigned will assume financial responsibility for its payment. The undersigned understands that an authorization is not a guarantee of payment and acknowledges the .responsibility for any payment not received from the insurance carrier within thirty (30) days from the date of service.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The undersigned certifies that he/she has received a copy of Florida O&P Services, 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 Florida O&P Services, lnc.'s health care operations. The notice of Privacy Practices also describes my rights and Florida O&p Services, lnc.'s duties with respect to my protected health information. The Notice of Privacy Practices is also posted in each office.

Florida O&P Services, lnc. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. The undersigned understands that he/she may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or by requesting one at the next time of his/her appointment.

_____ _____

Signature of Patient or Personal Representative Date Signed

_____

Patients Name (Please print)

_____ _____

Name of Personal Representative Description of Personal Representative's Authority

American Board Certified
Orthotic and Prosthetic Specialists

EQUIPMENT WARRANTY INFORMATION FORM

Every product sold or rented by our company carries a 1-year manufacturer's warranty. Florida O&P Services, Inc. will notify all Medicare beneficiaries of the warranty coverage, and we will honor all warranties under applicable law.

Florida O&P Services, Inc. will repair or replace, free of charge, Medicare-covered equipment that is under warranty. In addition, an owner's manual with warranty information will be provided to beneficiaries for all durable medical equipment where this manual is available.

I have been instructed and understand the warranty coverage on the product I have received.

_____ _____

Patient Signature Date Signed

Jacksonville
3636 University Blvd. S.
Suite 10
Jacksonville, Florida 32216
Phone: 904-737-7755
Fax: 904-737-7962

Orange Park
1555 Kingsley Ave.
Suite 505
Jacksonville, Florida 32073
Phone: 904-278-7025
Fax: 904-278-7027

St. Augustine
1797 Old Moultrie Road
Suite 110
St. Augustine, Florida 32084
Phone: 904-826-0027
Fax: 904-808-9973

Medicare (DMEPOS) Supplier Standards

Note: This is an abbreviated version of the supplier standards every Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) supplier must meet in order to obtain and retain 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 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 enrollment 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 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 and must instruct beneficiaries on 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 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 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 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).
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. A supplier must meet the surety bond requirements specified in 42 C.F.R. 424.57(c).
27. A supplier must obtain oxygen from a state-licensed oxygen provider.
28. A supplier must maintain ordering and referring documentation consistent with provisions found in 42 C.F.R. 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.

_____ _____

Signature Date Signed