Anew Life Prosthetics and Orthotics
6438 Woodward Avenue, Detroit, MI 48202-3216 / Phone 313-870-9610 Fax 313-202-8301

PATIENT INFORMATION

First Name: _____ Middle Name: _____ Last Name: _____

Nickname:_____

Date of Birth: _____ Gender: ☐ Male ☐ Female ☐ Other

Street Address: _____

City: _____ State: _____ ZIP Code: _____

Home Phone: _____ Mobile Phone: _____

Social Security Number: _____ E-Mail: _____

How were you referred to us: _____

Preferred method of contact: email/phone/text

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Emergency Contact Name: _____

Relationship: _____ E-Mail: _____

Phone: _____

Referring Physician name and phone:_____

Primary Physician name and phone:_____

Employment status: Employed, Unemployed, Self-employed, Student, Disabled, Retired, Child, Active Military Duty

Was your injury work or accident related? If so, give accident date, name and phone number of adjuster:

Are you any of the following: Diabetic / In Hospice / Resident of Nursing Home? Yes ____ No____

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INSURANCE INFORMATION

Primary Insurance Company: _____

Group #: _____ ID #: _____

Primary Insurance Type: ☐ HMO ☐ PPO ☐ Medicare ☐ Other: _____

Complete the following if you are not the policyholder for your primary insurance:

Insurance Policyholder: ☐ Spouse ☐ Child ☐ Parent ☐ Other: _____

Policyholder Name: _____ Date of Birth: _____

Policyholder Social Security Number: _____

Secondary Insurance Company: _____

Group #: _____ ID #: _____

PLEASE PROVIDE A COPY OF YOUR DRIVER LICENSE, INSURANCE CARD(s) AND CREDIT CARD

CONTINUED ON PAGE 2

I authorize the release of all medical information to my insurance company or doctor when requested.

I understand/agree that regardless of my insurance status, I am ultimately responsible for balance of my account for any services provided by Anew Life Prosthetics and Orthotics, LLC and/or any other collections or statement fees. I understand that payment is expected at the time of services unless other arrangements have been made.

I give permission for Anew Life Prosthetics and Orthotics, LLC to contact me about any matters regarding my care, insurance or remuneration. I have received a copy of DMEPOS Supplier Standards, if I am a Medicare patient.

I certify this information is true, accurate and complete. I will notify Anew Life Prosthetics and Orthotics, LLC of any changes in my status regarding the above information.

Signature: _____Date: _____
Self or parent/guardian of minor

If patient is physically or mentally unable to sign, please provide the following:

Representative name and relationship: _____

Representative Phone: _____

☐ I AGREE

We would like to send automated text and voice messages to the mobile phone number and email you have provided. These messages will be about your scheduled appointments. **By checking the box above, you agree to receive these types of messages.** Consent is not a condition of any purchase, and you can revoke your consent at any time by informing our office. Standard message and data rates may apply. You agree to notify us promptly if your mobile phone number or email address changes. This will ensure that you, and not someone else, receives messages intended for you.

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MEDICAL RELEASE FORM

I_____ Date of Birth: _____

Authorize release of my medical records to:

Anew Life Prosthetics and Orthotics
6438 Woodward Avenue
Detroit, MI 48202-3216
Phone: (313) 870-9610
Fax: (313) 202-8301

This Notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). We are strongly committed to protecting your medical information, also referred to as "Protected Health 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 Protected Health Information. This Notice describes your rights and our obligations with respect to the use or disclosure of your Protected Health Information.

OUR DUTIES TO YOU REGARDING PROTECTED HEALTH INFORMATION

"Protected Health Information" is individually identifiable health information. This information related to your past, present, or future physical or mental health or condition and related health care services; to the past, present or future payment for such health care services; and includes demographic information such as your age, address or e-mail address. Anew Life is required by law to do the following:

- Make sure that your Protected Health Information is kept private.
- Give you this Notice of our legal duties and privacy practices related to the use and disclosure of your Protected Health Information.
- Follow the terms of the Notice currently in effect.
- Describe how we will communicate any changes in this Notice to you.

Signature: _____Date: _____
Self or parent/guardian of minor

If patient is physically or mentally unable to sign, please provide the following:

Representative name and relationship: _____

Representative Phone: _____

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AUTHORIZATION OF PAYMENT

Patient Name: _____

Primary Insurance: _____

Secondary Insurance: _____

I instruct my insurance company to pay by check or ACH credit to "Anew Life Prosthetics and Orthotics LLC".

If my insurance prohibits direct payment to "Anew Life Prosthetics and Orthotics LLC', I Instruct my insurance company to pay "Anew Life Prosthetics and Orthotics, LLC" on my behalf via check or ACH credit. Check should be made payable to "Anew Life Prosthetics and Orthotics, LLC" and sent to:

Anew Life Prosthetics and Orthotics
6438 Woodward Avenue
Detroit, MI 48202-3216

The professional or medical benefits allowable and otherwise payable under my current insurance policy are payment toward the charges for the professional services rendered. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above and I have to pay any balance due over and above the Insurance payment.

I request that payments of Medigap or other benefits be made to "Anew Life Prosthetics and Orthotics, LLC" for any services furnished to me by this provider. I authorize any holder of medical Information to release to my Medigap or other insurance any information needed to determine these benefits payable for related Services. I agree that if updated insurance information is not provided at the time of service and/or time filing limitations has expired, I am responsible for the charges. I authorize Anew Life Prosthetics and Orthotics to initiate to the Insurance Commissioner for any reason on my behalf.

It is not Anew Life Prosthetics and Orthotics, LLC's responsibility to know my insurance benefits nor their responsibility to check my insurance benefits at time of service, it is done as a courtesy. Any information received from my insurance company regarding eligibility or benefits is not a guarantee of payment. Please refer to cancellation policy also given with the other required documents.
A photocopy of this agreement shall be considered as effective and valid as the original.

Signature: _____Date: _____
Self or parent/guardian of minor

If patient is physically or mentally unable to sign, please provide the following:

Representative name and relationship: _____

Representative Phone: _____

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CREDIT CARD POLICY

At Anew Life Prosthetics and Orthotics, we require keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance may or may not cover. but for which you may be liable. **Without this authorization, a billing fee of $25.00 will be added to your account for any balances that we must attempt to collect through mailing monthly statement. Furthermore, an "outstanding balance" charge of 1.5 percent of the total bill will be charged for each month that the bill remains unpaid.**

Your credit card information is kept confidential and secure. Payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account.

I authorize Anew Life Prosthetics and Orthotics to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

❑ Amex ❑ Visa ❑ Mastercard ❑ Discover Credit

Card Number: _____

Expiration Date _____ CVV: _____

Cardholder Name _____

Billing Address: _____

City _____ State_____Zip _____

TO PAY VIA CREDIT CARD, GOOGLE OR APPLE PAY: https://collectcheckout.com/r/2weg6

TO PAY VIA OUR SECURE ONLINE PORTAL VIA WEBSITE: Cart (collectcheckout.com)

I (we), the undersigned, authorize and request Anew Life Prosthetics and Orthotics, to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility. This authorization relates to all payments not covered by my insurance company for services provided to me by Anew Life Prosthetics and Orthotics. This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60 day notification to Anew Life Prosthetics and Orthotics in writing and the account must be in good standing.

Patient Signature: _____ Date: _____

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PATIENT HISTORY FORM

Name:_____ DOB:_____

Briefly describe your present symptoms related to today's office visit

_____

Please list the names of other practitioners and/or physicians you have seen for this problem.

_____

General Health: Fair Poor Good Excellent

Personal History

Are you condition results of an accident? If, yes: Auto Work Other:

Date of Injury: _____ Type: Traumatic Acquired Congenital

Amputation Level: _____

What is your highest education? _____

What is your current or past occupation? _____

If still currently working what are your number of Hours/Week: _____

Personal Medical History: Do you now or have you ever had the following condition'?

Alzheimer Disease	Arthritis	Alcoholism
Cancer	COPD/Asthma	Congestive Heart Failure
Depression	Diabetes	Heart Disease
Hepatitis	HIV/AIDS	Hypertension/Hypotension
Smoking	GER.D	Glaucoma
Kidney Disease	Osteoporosis	Pulmonary Disease
Pacemaker/Defibrillator	Parkinson's Disease	Seizures
Smoking/Vaping	Dialysis	Drug Usage
Vascular Disease/PVD	Currently Pregnant	Other:

List Any Medication: _____

List of any other conditions that you feel might affect your treatment (including date and descriptions of surgeries): _____

List of Any Surgeries and Surgeons: _____

Do you have any prior prosthetic/orthotic experience? if yes, briefly explain:

_____

Therapy: Occupational Physical # of Days per Week: _____On (Circle): M T W T F

List of all known allergies: _____

Other Additional Information: _____

Sign:_____ Date: _____

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(e).

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 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 for 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 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(O.**
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.**

HIPAA Documents and Supplier Standards Receipt

_____ have received the following document(s) and I agree to the terms listed within them:

Document Name	Description
Anew Life Patient Intake Form	Patient Registration Form where all fields are completed by patient.
Appointment Policy	Patient responsibilities of appointments held at Anew Life Prosthetics and Orthotics LLC.
Authorization of Payment	Authorization of payment: form where all fields are to be completed by patient.
Credit Card Policy	Credit Card policy and form kept in patient file.
Financial Responsibility Information	Financial responsibility information based on insurance type.
Financial Responsibility Notice	Patient notice of financial responsibilities policy with Anew Life Prosthetics and Orthotics 'LLC.
Medical History	A form completed by patient regarding their medical history information.
Medical Release Form	Medical Release of Information form where all fields are completed by patient.
Medicare Standards	Mandated federal standard policies and procedures applicable.
Patient Rights	Patient right and responsibilities for Anew Life Prosthetics and Orthotics LLC to provide product/service.

Signature: _____ Date: _____

PATIENT'S RIGHTS AND RESPONSIBILITIES

You have the right to:

- Receive clear, complete information about your surgery, medical care and therapy.
- Be given considerate, respectful and compassionate care.
- Be treated without discrimination based on race, ethnicity, national origin, age, gender, sexual orientation, gender identity or expression, physical or mental disability, religion, language or ability to pay.
- Have privacy and confidential treatment and communication about your care.
- Be involved in developing your plan of care.
- Set goals for what you want to achieve.
- Set goals for your physical and emotional well-being.
- Set goals for preventing other health conditions that may result from your amputation, including further surgery.
- Receive information on how to contact an Amputee Coalition of America certified peer visitor.
- Be informed about funding for healthcare and your financial responsibility.
- Be informed about prosthetic and orthotic services, healthcare products, new technology and insurance coverage.
- Select qualified healthcare providers.
- Ask for help when you are unhappy with healthcare products or the care you receive.

You have the responsibility to:

- Actively be involved in your plan of care.
- Provide accurate, up to date and complete information about your health, address, contact information, date of birth, insurance carrier, and employment.
- Take responsibility for the consequences of not following instructions or refusing care.
- Learn about products and services that are appropriate, safe and effective for you.
- Express concerns about quality of care, billing practices, and products or services.
- Aid with reimbursement as required by your healthcare insurance and provider.
- Provide information about your past and current medical history, including symptoms pain, treatments, hospitalizations, medications and report any changes in your health.
- Ask questions if you do not understand the directions or treatment being given by a provider.
- Keep scheduled appointments or call within 24 hours if you need to cancel or reschedule.
- Pay your bills or work with us to find funding to meet your financial obligations.
- Pick up and pay for products and devices ordered, serviced, or provided on your behalf.

FINANCIAL RESPONSIBILITY

We *accept payment by: cash, check, credit card or 3rd party patient financing.* ***NOTE: Charges not covered by your insurance plan, co-payments and deductibles, are your responsibility.*** *Returned check fee: $45.00 or state max.*

If you have:	***You are responsible for:***	
Insurance Plan with whom we have a contract	If the services you receive are covered by the plan: patient portion (co-pays, deductibles, co-insurance, etc.) on or before date of delivery. If the services you receive are not covered by the plan: 50% down and remaining 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/ we are NOT an "in-network" provider	50% down with remaining payment in full on or before date of delivery	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 8	If you have Medicare Part B, and have not met your deductible, we ask that it be paid on or before date of delivery. If you do not have secondary insurance, Medicare co-insurance amount on or before date of delivery. If the total services are less than $250, full payment on or before date of delivery. Payment for any services not covered by Medicare on or before date of delivery.	Contact Medicare and secondary insurance plan (if applicable) to obtain your eligibility and benefit information. Submit your insurance claim to Medicare, as well as any claims to your secondary insurance.
Medicaid	Depending on each state's Medicaid program, if the services you receive are covered by Medicaid: patient portion (if applicable) on or before date of delivery. Payment for any services not covered by Medicaid on or before date of delivery date of delivery.	Contact local Medicaid office to obtain your eligibility, benefit information and patient portion (if applicable) as well as obtain prior authorization (if applicable).
Worker's Comp	If the services you receive are covered by Worker's Comp. or Auto: patient portion (if applicable) on or before date of delivery. Payment for any services not authorized by Worker's Comp or Auto Claim: on or before date of delivery.	Call your Worker's Comp plan or Auto Adjuster to obtain our eligibility, benefit information and patient portion (if applicable) as well as obtain prior authorization (if applicable).
No Insurance	50% down with remaining payment in full on or before date of delivery	Advise you regarding charges for services provided.