NEW HORIZONS
ORTHOTIC & PROSTHETIC SERVICES

Section 1- Patient Information

Patient First Name: _____MI: _____Last Name: _____

Nick Name: _____ Email Address: _____

SSN: _____-_____-_____ DOB: _____/_____/_____ Age: _____ Sex: M / F Marital Status: S|M|W|D

Home Address: _____City: _____State: _____Zip Code_____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

Patient's Employer: _____Work number: (_____) _____-_____

Employer Address: _____City: _____State: _____Zip code: _____

Referring Physician: _____

Primary Care Physician: _____

How did you choose New Horizons O & P to be your Orthotic-Prosthetic provider?

Friend _____Physician _____Insurance _____Other_____

Section 2- Responsible Party/ Spouse / Parent / Guardian

Name: _____ SSN: _____-_____-_____DOB_____/_____/_____Age: _____

Home Phone: (_____) _____-_____Cell Phone: (_____) _____-_____

Relationship to the patient: Spouse / Parent / Guardian / Other (explain) _____

Address: _____City: _____State: _____Zip Code: _____

Employer: _____Work #: (_____) _____-_____

Employer Address: _____City: _____State: _____Zip Code: _____

Section 3- Emergency Contact

First Name: _____MI: _____Last Name: _____

Home Phone: (_____) _____-_____Cell Phone: (_____) _____-_____Work #: (_____) _____-_____

Address: _____City: _____State: _____Zip Code: _____

Relations to patient: _____

Section 4- Same or Similar Device

Have you had a same or similar device in the last 5 years? Yes_____ No _____

If yes, what type: _____

_____

Section 5- Insurance Information

Primary Insurance: _____Policy Holder: _____

Policy holder DOB: _____/_____/_____ Policy holder SSN: _____-_____-_____ Relationship_____

ID #: _____ Group #: _____

Address: _____ City: _____ State: _____

Phone: (_____) _____-_____

Secondary Insurance: _____Policy Holder: _____

Policy holder DOB: _____/_____/_____ Policy holder SSN: _____-_____-_____ Relationship_____

ID #: _____ Group #: _____

Address: _____ City: _____ State: _____

Phone: (_____) _____-_____

Worker's Comp? Y/N **Is this due to an Auto/Home Accident? Y/N**

Date of Injury_____/_____/_____

Insurance: _____ Claim #: _____

Address: _____ City: _____ State: _____

Adjuster/Contact: _____ Phone: (_____) _____-_____

Fax #: (_____) _____-_____

I hereby request New Horizons O & P to provide any prosthetic/orthotic services necessary, per my physician's prescription.

Patient's Signature: _____ Date: _____/_____/_____

Responsible Party: _____ Date: _____/_____/_____

Patient Financial Policy

Please initial next to one of the following payment agreements

_____**Health Insurance Carriers:**
I am covered by an insurance plan and hereby authorize all payments go directly to New Horizons Orthotics & Prosthetics. I agree to pay the amount my insurance plan indicates I am responsible for at the time of service. I agree to provide written authorization prior to my receiving service if this is required by my insurance plan. Covered benefits vary between insurance plans. Some insurance plans require pre-authorization for services. Therefore, make sure have pre-authorized your service, if necessary. Additionally, it is your responsibility to understand the limitations and exclusions of your policy. If you have any questions regarding your coverage, please contact your plan administrator or the insurance company's customer service department.

_____ **Medicare:** I am a Medicare recipient, and understand New Horizons Orthotics & Prosthetics accepts assignment of Medicare claims. I understand that New Horizons Orthotics & Prosthetics will file my claims for me to both my Medicare and secondary insurance.

_____ **Medicaid:** I am covered by Medicaid and verify that my coverage is active. If my eligibility status changes, I will let New Horizons Orthotics & Prosthetics know. I understand that if I am seen without coverage, I am responsible for the charges incurred. Should my Medicaid plan have a co-pay or deductible requirement, I agree to make payment the time of service.

_____ **No Insurance:** I have no assignable third-party coverage and New Horizons Orthotics & Prosthetics will not file an insurance claim for my services. We ask that you remit payment within ten days of receiving your monthly statement. We are happy to accept payments by cash, check, or credit card. If your account reaches 90 days past due and you have not contacted us to make a payment arrangement, your account may be turned over to our collection agency.

_____ **Law Suite/Liability:** Our policy is to file liability claims on behalf of our injured patients. However, if denial is received or if your claim is not settled within six months, we will ask that you begin to make regular monthly payments. Failure to make these payments may result in your account being turned over to a collection agency. We can also submit to your health insurance for payment at your request as one as the information is provided to us. We will work with you to establish a reasonable monthly payment plan to accommodate your needs. If an attorney is involved, we will file a lien with them, but this is no way releases your responsibility in making required monthly payments... ****Fill out Liability Form**

_____ **Workers Compensation:** I have a work-related injury. New Horizons Orthotics & Prosthetics will bill my employer for the services rendered, and in the event of a dispute with my employer about the work-relatedness of my injury, I accept full responsibility for payment of my account, I will provide a copy of my personal health insurance card to New Horizons Orthotics & Prosthetics. ****Fill out WC Form**

Please initial all five lines below:

_____ Assignment of Benefits: I hereby authorize New Horizons Orthotics & Prosthetics to furnish information to the above-named insurance carrier(s) concerning my services and hereby assign all payments for services rendered to New Horizons Orthotics & Prosthetics. I understand that I am responsible for all charges, even those not paid by my insurance.

_____ Medical Authorization: I hereby authorize release of any and all medical records to New Horizons Orthotics & Prosthetics. I also consent to the release of my health care records to be reviewed by my insurance company or any necessary audits within New Horizons Orthotics & Prosthetics.

_____ HIPAA Notice of Privacy Practice: I acknowledge that New Horizons Orthotics & Prosthetics has offered or supplied me with a copy of their HIPAA Notice or Privacy Practice regarding policies and procedures concerning my Protected Health Information (PHI). I agree to release authorization to New Horizons Orthotics & Prosthetics to use my PHI as deemed necessary for treatment, billing and the purposes mentioned in the notice.

_____ Medicare Supplier Standards: I have been offered or supplied to me a copy of the Medicare Supplier Standards.

_____ Patient Rights and Responsibilities: I have been offered or supplied to me a copy of the Patient Rights and Responsibilities.

_____ _____ _____

Patient or Legal Guardian Signature | Date | Relationship

HIPAA Agreement

I have reviewed this practice practices form and hereby acknowledge that I have read and understand the privacy practices of New Horizons Orthotics & Prosthetics.

_____
Name of Patient

_____ _____
Signature of Patient Date

_____ _____
Signature of Patient Representative Relationship to Patient

By this form I give permission to New Horizons Orthotics & Prosthetics to discuss my medical condition with the following people:

Spouse:_____

Parents:_____

Children:_____

Other Family Members: _____

Caregivers: _____

Guardian: _____

Close Personal Friends: _____

_____
Name of Patient

_____ _____
Signature of Patient Date

_____ _____
Signature of Patient Representative Relationship to Patient

Patient Rights and Responsibilities

Patient Rights:

1. The patient has the right to considerate and respectful service.
2. The patient has the right obtain service without regard to race, creed, national origin, sex, age, disability, diagnosis or religious affiliation.
3. Subject to applicable law, the patient has the right to confidentiality of all information pertaining to his/her medical equipment service. Individuals or organizations not involved in the patient's care, may not have access to the information without the patient's written consent.
4. The patient has the right to make informed decisions about his/her care.
5. The patient has the right to reasonable continuity of care and service.
6. The patient has the right to voice grievances without fear of termination of service or other reprisal in the service process.

Patient Responsibilities:

1. The patient should promptly notify the Home Medical Equipment Company of any equipment failure of damage.
2. The patient is responsible for any equipment that is lost or stolen while in their possession and should promptly notify Home Medical Equipment Company in such instances.
3. The patient should promptly notify Home Medical Equipment Company of any changes to their address or telephone.
4. The promptly notify the Home Medical Equipment Company of discontinuance of use.
5. The patient should notify the Home Medical Equipment Company of discontinuance of use.
6. Except where contrary to federal or state law, the patient is responsible for any equipment rental and sale charges which the patient's insurance company/companies does not pay.

After hours please call:

308-698-0500

Or

308-380-5780

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 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(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.

HIPAA NOTICE OF PRIVACY PRACTICES

New Horizons Orthotics & Prosthetics, LLC
5609 1st Ave, Ste A2
Kearney, Nebraska 68847

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMAITON. PLEASE REVIEW IT CAREFULLY.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your practitioner, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to your, to pay your health care bills, to support the operation of the physical therapist's practice and any other uses required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Options: We may use or disclose, as needed, your protected health information in order to support the business activities of our practice. The activities include, but are not limited to quality assessment activities, employee review activities, licensing and conducting or arranging for other business activities. For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your practitioner is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include; as Required by Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, Authorization or Opportunity to Object unless required by law.

You may revoke this Authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

Your have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected heath information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e., electronically.

You have the right to have you physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact o your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on or before **January 1st, 2020**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.