*** THE FOLLOWING INFORMATION MUST BE FILLED OUT OR IT WILL NOT BE ACCEPTED ***

McCleve Orthotics & Prosthetics

NAME: (First, Middle, Last)	PREFERRED NAME:	TODAY'S DATE:
		____/ ____/ ____
DATE OF BIRTH: ____ / ____ /____	☐ Male ☐ Female	SOCIAL SECURITY #: (OPTIONAL) _____ - _____ -_____
MARITAL STATUS: (circle) S M D W	SPOUSE/PARTNERS NAME: _____	SPOUSE/PARTNERS PHONE: (____) _____- _____
EMAIL: (this is NOT for advertising)		

VOCATIONAL CATEGORY: (circle)

Employed Full Time / Employed Part Time / Retired / Unemployed / Homemaker / On Disability / Student

AZ ADDRESS:	DO YOU LEAVE FOR THE SUMMER/WINTER? YES NO
_____ Apt/Lot: _____ City: _____ State: _____ Zip: _____	WHAT MONTHS ARE YOU IN AZ? _____ TO _____. OUT OF STATE/COUNTRY ADDRESS: _____ _____
HOME NUMBER: (_____) _____ - _____. CELL NUMBER: (_____) _____ - _____.	WORK NUMBER: (_____) _____ - _____. OTHER NUMBER: (_____) _____ - _____.
DO WE HAVE PERMISSION TO LEAVE A VOICEMAIL? ___ YES OR ___ NO	ARE YOU CURRENTLY LIVING IN A FACILITY/GROUP HOME? ___ YES OR ___ NO PLEASE SPECIFY: _____

EMERGENCY CONTACT NAME:	RELATIONSHIP:	EMERGENCY CONTACT'S PHONE NUMBER
_____	_____	(_____) _____ - _____.
EMERGENCY CONTACT NAME:	RELATIONSHIP:	EMERGENCY CONTACT'S PHONE NUMBER
_____	_____	(_____) _____ - _____.

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DOCTOR'S INFORMATION

REFERRING PHYSICIAN: **PHONE:** _____ (_____) _____- _____	**PRIMARY CARE PHYSICIAN:** **PHONE:** _____ (_____) _____- _____
SURGEON: (IF APPLICABLE) **PHONE:** _____ (_____) _____- _____	**DIABETIC DR:** (IF APPLICABLE) **PHONE:** _____ (_____) _____- _____
WHEN WAS YOUR LAST DOCTORS APPOINTMENT? _____ / _____ / _____	**WHO WAS THE APPOINTMENT WITH?** _____

INSURANCE INFORMATION

AN INSURANCE CARD IS NOT NEEDED TO COMPLETE THE FOLLOWING

PRIMARY INUSURANCE: (card is not needed for the following information)

Company: _____ **Subscriber Name:** _____

Relationship: _____ *** Subscriber Date of Birth:** _____

SECONDARY INSURANCE: (card is not needed for the following information)

Company: _____ **Subscriber Name:** _____

Relationship: _____ *** Subscriber Date of Birth:** _____

TERTIARY INSURANCE: (card is not needed for the following information)

Company: _____ **Subscriber Name:** _____

Relationship: _____ *** Subscriber Date of Birth:** _____

Accident/ Workman's Comp Insurance: **Injury:** _____ **Injury Date:** _____

Claim Number: _____ **Adjusters Name:** _____ **#: (**_____**)** _____**-** _____

Employer: _____ **Employer's Phone # :(**_____**)** _____**-** _____

*** THE FOLLOWING INFORMATION MUST BE FILLED OUT OR IT WILL NOT BE ACCEPTED ***

Name: _____ Weight: _____lbs. Height: ____' ____"

How is your general health?: Poor Fair Good Excellent

Please circle your activity level: Low Medium Active Highly Active

Falls in the last 6 months? ___ Yes ___ No

If yes, how many falls? _____

Hospital, ER, or Urgent Care visits in the last 6 months? ___ Yes ___ No

Related to the fall? ___ Yes ___ No

Please check all that apply:

- **Your injury is a result of an accident from employment.**
- **Your injury is a result of an auto accident.**
- **Your injury is a result of any other type of accident.**
- **Condition since birth**

Injury Date: ____/____/____ (if applicable) The state where injury occurred _____ (AZ, CA, WY, ECT...)

Please explain the reason for your visit OR how the injury occurred:

_____

_____

_____

Have you received this device OR a similar brace within the past five years? ___ Yes ___ No

If marked Yes, please specify: _____

_____

_____

Do you have an Amputation? __ Yes __ No

Amputation Level:

__ Above Knee
__ Through Knee
__ Below Knee
__ Through Ankle
__ Partial Foot
__ Above Elbow
__ Below Elbow

Amputation Reason:

__ Trauma
__ Circulation
__ Born without Limb
__ Tumor
__ Infection

Amputation date:

____/ ____/ _____

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Do you have any allergies? Please specify:

_____

_____

_____

Are you currently taking any pain medication, related to the reason you came in today? Please specify:

Name: _____

Dosage: _____

Frequency: _____

Have you had any major surgeries related to the reason you came in today?

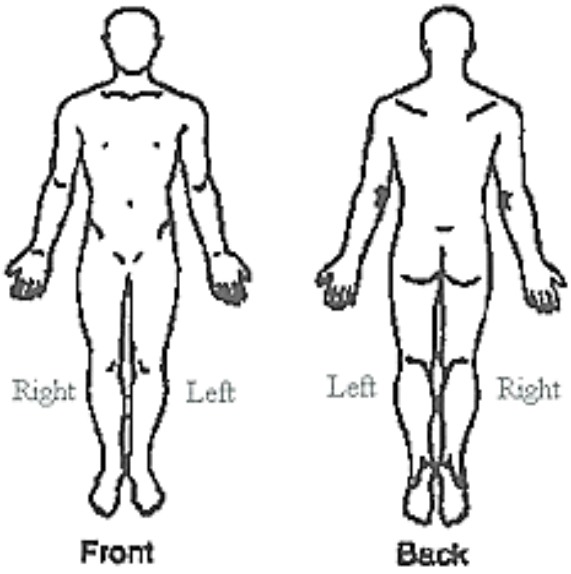
Surgery type: _____

Year: _____

Do you have or have had any of the following conditions:

__ **Alzheimer's or Dementia**
__ **Anxiety**
__ **Asthma**
__ **Brain Injury/TBI**
__ **Cancer**
__ **Depression**
__ **Diabetes Type 1**
__ **Diabetes Type 2**
__ **Hearing Loss**
__ **Heart Problems**
__ **Hepatitis**
__ **High Blood Pressure**
__ **HIV**
__ **Infections**
__ **Intestinal Problems**
__ **Kidney Disease**
__ **Liver Disease**
__ **Migraines**
__ **MRSA**
__ **Neurological Problems**
__ **Obesity**
__ **Osteoarthritis**
__ **Osteoporosis**
__ **Parkinson's Disease**
__ **Pulmonary Disease (TB)**
__ **Rheumatoid Arthritis**
__ **Seizure Disorders**
__ **Skin Problems**
__ **Stomach Problems**
__ **Stroke/TIA/CVA**
__ **Vascular Disease**
__ **Vision Problems**

Other Conditions: _____



Please circle or point to the area you are feeling pain.

On a scale of 1- 10 how bad is your pain?

1 2 3 4 5 6 7 8 9 10
Better **Worse**

Recent change in weight?

__ **Yes** __ **No**

__ **Loss** **How Much** _____ **Lbs.**

__ **Gain**

McCleve Orthotics & Prosthetics
DJLW Health Services Inc.
5432 Southern Ave, Ste 106
Mesa, Arizona
P: (480) 981- 6767 F: (480) 802-2330

Notices of Privacy Practices

I acknowledge that I have received a copy of the "Notice of Privacy Practices". This Notice of pertain the Health Insurance Portability & Accountability Act of 1996 ("H.I.P.P.A.")

_____ _____ ____/_____/_____

Signature **Print Name** **Date**

Assignment of Benefits & Medical Release

Payment for services rendered is due at the time, unless McCleve Orthotics & Prosthetics has agreed otherwise in writing. To extend payment is not made when due. I hereby irrevocably assign to McCleve Orthotics & Prosthetics for and in consideration of the services to be rendered to me by McCleve Orthotics & Prosthetics, all related medical and/or surgical benefits to which I am or become entitled (Including Medicare, Medicaid, Private Insurance, and/or under any health plan or medical plan sponsored by my employer and/or the responsible party's employer).

I hear by irrevocably direct that the insurer, employer, or other party responsible for providing such benefits remit same directly to McCleve Orthotics & Prosthetics, 5432 E Southern Ave, Suite 106, Mesa, AZ 85206.

I understand that I am primarily responsible for all charges incurred with McCleve Orthotics & Prosthetics, whether or not any part is payable by any such insurance and that, in the event McCleve Orthotics & Prosthetics is not timely paid.

I recognize that it is ultimately my sole responsibility to cause the insurer of health plan, if any, to promptly remit payment to McCleve Orthotics & Prosthetics.

I agree to pay McCleve Orthotics & Prosthetics for my deductible, co-insurance, and non-covered service(s).

I understand that if my insurance company sends payment for my prosthetic or orthotic item(s) to me instead of McCleve Orthotics & Prosthetics, it is my responsibility to immediately forward payment to McCleve Orthotics & Prosthetics.

I agree to pay reasonable collections and/or attorney's fees and costs should it become necessary to enforce payment on a past due amount. We require you pay your bills in full within 60 days of the receipt of your invoice(s) or to make satisfactory arrangement with McCleve Orthotics & Prosthetics before your account reaches 60 days.

If any checks written to McCleve Orthotics & Prosthetics are returned for insufficient funds, there will be a $30.00 service fee added to your balance.

I hereby authorize McCleve Orthotics & Prosthetics to release all information necessary to secure payment.

I hereby authorize the release of all or any medical records to McCleve Orthotics & Prosthetics upon request, which is necessary to complete the process of my claim or to obtain authorization for my service(s).

A photo of the assignment shall be considered as valid as the original. I further certify that the information provided by me, is true, accurate, and complete.
The fact that I may not be covered by insurance does not relieve my personal obligation to pay all fees due to McCleve Orthotics & Prosthetics. **I have read and agree to all the terms of this agreement.**

_____ _____ ____/_____/_____

Signature **Print Name** **Date**

McCleve
ORTHOTICS AND PROSTHETICS

McCleve Orthotics & Prosthetics
5432 East Southern Avenue, Suite 106 Tel: (480) 981-6767
Mesa, AZ 85206 Fax: 480-802-2330

Notification of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please review it carefully.

The Health Insurance Portability & Accountability Act of 1996 ("HIPPA") is a federal program which requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPPA" provides penalties for covered entitles that misuse personal health information.

As required by "HIPPA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may disclose your health information.

We may use or disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilizing review. An example of this would be sending a bill to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. We will not however, use your medical information for marketing communications without your written consent. An example would be an internal quality assessment review.

We may also create and distribute de-identifiable health information by removing all references to individuality identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your written consent.

You have the following rights with request to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are not, however, required to agree to a request restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information. We reserve the right to charge a cost-based fee for duplicating and postage.
- The right to amend your protected health information.
- The right to receive and accounting disclosure of protected health information.
- The right to obtain a paper copy of this notice upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practice with respect to protected health information. This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Policy and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practice form this office. You have recourse if you feel your privacy has been violated. You have the right to file written complaint with our office of with the department of Health Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filling a complaint.

Please contact us for more information: Joyce R. McCleve, Privacy Officer
5432 E. Southern Ave. Suite 106
Mesa, AZ 85206
Office: 480-981-6767

MEDICARE DMEPOS SUPPLIER STANDARDS

Note: This is an abbreviated version of the supplier standards every Medicare DMEPOS supplier must meet. 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 & respond to complaints of beneficiaries & 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 with certain exceptions