MID-FLORIDA Prosthetics & Orthotics

Visit us at www.midflpros.com

Thank you for choosing Mid-Florida Prosthetics & Orthotics. Our friendly staff is ready to help you with all your prosthetic and/or orthotic needs. Our goal is to provide you with high quality, cost-effective care, and service under the direction of your physician.

When You Arrive - During your initial comprehensive evaluation, one of our practitioners will ask about the nature of your condition, lifestyle, interests, and levels of your activity. The more we know about how you live, work, and play, the more effective we will be in successfully creating a device appropriate to your needs. We will discuss your options.

Measuring for the device - Depending on your situation, the practitioner may measure or make a custom impression for your prosthetic or orthotic device.

Schedule your follow up visit - At the end of your initial visit, you will be asked to make a return appointment for the actual fitting of your prosthetic or orthotic device.

Initial follow-up fitting/delivery visit - When you return, your practitioner will fit the prosthetic or orthotic device. We will make adjustments if necessary. In most cases you will be able to leave our office the same day with your new device.

Additional fitting visits - Some devices may require additional adjustments to fit and function to their fullest. You may have to return for final adjustments. We will do our best to keep the number of office visits to a minimum. We want you to leave with the best fitting device possible.

Follow-up visits - Additional follow-up visits and maintenance appointments may be scheduled to make sure the device is working properly and that you are wearing it correctly. Your practitioner will also discuss the coordination of your follow-up care with your physician and/or therapist.

Insurance Coverage - Please call your insurance company to verify your coverage for prosthetics and/or orthotics, and to verify your coinsurance percentage and deductible amount. Our office staff will also be available to assist you in confirming your coverage and financial responsibility.

Many insurance policies require the patient to pay for a percentage of our charges and an annual deductible. You are responsible for paying a portion of this amount at your first appointment, usually half of the total amount for which you are personally responsible. Your entire coinsurance and deductible are due before your prosthetic or orthotic device is delivered.

HERE IS THE DOCUMENTATION THAT IS REQUIRED FROM YOUR DOCTOR BEFORE WE CAN BEGIN FILLING YOUR PRESCRIPTION and PROCESSING YOUR DEVICE:

Detailed Written Order: Only your doctor can provide you or us with a detailed written order.

Doctor's Notes: Only your doctor can provide you or us with their detailed notes from your visit.

Please Note: The most common reason for delays in the delivery of your device(s) is the lack of paperwork from the physician's office. We understand he/she is busy and often gets backed up with paperwork, therefore, Mid-Florida Prosthetics & Orthotics will reach out to your doctor's office requesting this information. It has been our experience that the medical industry responds to patients with greater urgency than partner companies such as Mid-Florida Prosthetics & Orthotics. To ensure we get you up and going as quickly as possible, we may request your help in requesting these documents from your doctor. If you have not yet visited your doctor, ask us for a packet before leaving our office.

Ocala	2300 SE 17th Street Suite 401 • Ocala, FL 3447 • Tel: 352-351-3207 • Fax: 352-351-3267
Ocala West	9401 SW Hwy 200 Suite 404 • Ocala, FL 34481 • Tel: 352-873-0925 • Fax: 352-873-0909
Gainesville	6608 NW 9th Blvd • Gainesville, FL 32605 • Tel: 352-331-3399 • Fax: 352-331-9927
Lake City	221 SW Stonegate Terr, Unit 107 • Lake City, FL 32024 • Tel: 386-755-5774 • Fax: 386-755-5785
Leesburg	601 E. Dixie Hwy. Suite 806 • Leesburg, FL 34748 • Tel: 352-435-4500 • Fax: 352-435-4516
The Villages	13940 US Hwy 441 Suite 302 • Lady Lake, Fl 32159 • Tel: 352-259-3084 • Fax: 352-259-3417
Tallahassee	3401 Capital Medical Blvd • Tallahassee, FL 32308 • Tel: 850-203-2016 • Fax: 850-280-6127

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Assignment of Benefits

I authorize direct payment and insurance benefits to be made directly to Mid Florida Prosthetics & Orthotics for any product or services provided by Mid Florida Prosthetics & Orthotics on a continuing basis unless specifically revoked by me.

Release of Information

I authorize any holder of medical or other information about me to be released to Mid-Florida Prosthetics & Orthotics their assignees or successors, such communication being needed to determine benefits payable for related claims for supplies or services furnished by Mid Florida Prosthetics & Orthotics. I authorize Mid Florida Prosthetics & Orthotics to file my insurance claims and to release any medical information needed to my insurance company to process any medical claims.

Photographic Consent

I authorize any photograph of me and/or my device by Mid Florida Prosthetics & Orthotics in connection with my diagnosis, treatment, or for reimbursement purpose. Photographs will be incorporated within the patient's medical record for documentation of care.

HIPAA Privacy Policy

We are required by law to provide you with our Notice of Privacy Practices which explains how we use and disclose your health information. We are also required to obtain your signature acknowledging that this notice has been made available to you. A copy of Mid-Florida Prosthetics & Orthotics Notice of Privacy Practices has been made available to me.

Device Warranty Policy

We stand behind the quality of every device we fabricate as well as the quality of the service we provide. Our company's warranty policy is 90 Days from the date of delivery of the device. If it is clearly evident that the device has some defect in fabrication or that the device did not properly "fit" the patient at the outset, our staff will make all necessary adjustments, normal wear and tear does not constitute repair and/or replacement at no charge. Each practitioner should always give verbal and written instructions to the patient regarding the wear and care of the device the patient received.

Emergency Maintenance and Repair Policy

We are very aware of the importance of our patients wearing their given device. Therefore, if a device needs immediate repair or replacement, it will receive the highest priority, and every effort will be made to repair or replace the device in the shortest period of time possible.

After Hour and Weekend Coverage

All after hours and weekend calls will forward to our Answering service. In the event of an emergency our on -call clinician will be notified

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Patient Information

Last: _____First: _____Middle: _____

Male: _____ Female: _____ DOB: _____ Social Security #: _____

Email Address: _____

Mailing Address: _____

City: _____ State: _____Zip Code: _____

Alternate Address: _____

City: _____ State: _____Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Occupation: _____ Marital Status: _____

Parent or Legal Guardian (if Minor): _____

Mailing Address: _____

City: _____ State: _____Zip Code: _____

Relationship to Patient: _____

Person to notify in case of an Emergency:

Name: _____ Phone: _____

Relationship: _____

Are you an Amputee? Yes____ No____ Height_____ Weight_____ Shoe Size_____

Date of Injury: _____

Date of Amputation: _____

Referring Physician: _____

Primary Care Physician: _____

Diabetic Physician: _____

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Insurance Information

Primary Insurance: _____ Policy#: _____

Name of Insured: _____ DOB: _____

Relationship to patient: Self: _____ Other: _____

Secondary Insurance: _____ Policy#: _____

Name of Insured: _____ DOB: _____

Relationship to patient: Self: _____ Other: _____

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Compound Authorization for Release of Information

Please check either "Yes" or "No" and initial each line. Do you authorize Mid-Florida Prosthetics & Orthotics to:

1. Mail medical reports through US Postal Service? ____Yes ____No ____Initial
2. Leave a message on Voice Mail? ____Yes ____No ____Initial

   Cell Phone Number: _____
3. Leave a message on the Answering Machine? ____Yes ____No ____Initial ____

   Home: _____ Work: _____
4. Give information to your employer? ____Yes ____No ____Initial

   Name: _____
5. Give information to your spouse? ____Yes ____No ____Initial

   Name: _____
6. Give information to your parents? ____Yes ____No ____Initial

   Name: _____

   Name: _____
7. Give information to your children? ____Yes ____No ____Initial

   Name: _____

   Name: _____

   Name: _____
8. Give information to friends or others? ____Yes ____No ____Initial

   Name: _____

   Name: _____

WORK COMP OR AUTO ACCIDENT

Is this injury related to Worker's Comp? Yes _____ No _____

If yes, please provide the date of injury _____

Is this injury related to an Automobile Accident? Yes _____ No _____

If yes, please provide the date of injury _____

Rights of the Patient

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed in this document by signing a written notification to Mid-Florida Prosthetic & Orthotics HIPAA Officer.

I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed because of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Print Name of Patient: _____

Patient (guardian) Signature: _____

Date: _____

Employee: _____

Time: _____

Patient Financial Policy

Thank you for choosing Mid-Florida Prosthetic & Orthotics for your health care needs. The patient financial policy has been developed to assist in answering your questions regarding patient and insurance responsibility for services rendered. Your understanding of and compliance with our patient financial policy is important. Please read the policy below and ask the staff any questions you may have, and sign as indicated. The original will be maintained in your file and a copy may be provided to you upon your request.

1. **PROOF OF INSURANCE:** All patients must complete our patient information form before seeing the clinician. Mid-Florida Prosthetic & Orthotics participates with a large variety of insurance plans, including Medicare. Please confirm with our staff that we participate with your specific insurance plan. If you are not insured by a plan that we participate in, payment in full is expected at time of service unless prior arrangements have been made. It is your responsibility to ensure that we have your correct information and an up-to-date copy of your insurance card.
2. **UPDATED CHANGE OF INFORMATION & COVERAGE:** We will ask you to update this whenever you have a change in address, employment, Insurance, etc. However, it is your responsibility to make us aware of these changes, if you fail to provide us with the correct updated information, you will be responsible for the cost of the services rendered and your payment will be expected.
3. **CO-PAYMENTS, DEDUCTIBLES & CO-INSURANCE:** All co-payments, deductibles & co-insurance must be paid at the time of service. Payment of your copayments, deductibles & coinsurance is plan of your contract agreement with your insurance plan. Our failure to collect payment may be a violation of billing compliance and may be considered as an act of fraud by your insurance plan.
4. **NON-COVERED SERVICES:** Please be aware that some or all the services you receive may not be covered or considered reasonable or necessary by your insurance plans. If you elect to have these services, you will be asked to sign an ABN waiver and payment in full at the time of service will be expected unless prior arrangements have been made.
5. **REFERRALS:** Some insurance plans require a referral from a primary care physician to obtain the services of a specialist, such as prosthetics or orthotics. These health plans will not pay for services rendered without a referral. It is 'YOUR' responsibility to obtain a referral prior to treatment. If you have not obtained the necessary referral, you may either reschedule your appointment or, if allowed by your insurance company, sign a waiver agreeing to pay for the service at the time it is rendered.
6. **AUTHORIZATIONS**: Obtaining prior authorization for services is not a guarantee of payment of benefits. A prior authorization means that the information given at that time meets the medical necessity for the services not a guarantee of payment. Your insurance plan will confirm to you that even though the services may be authorized, the services may not be covered under your plan and a decision for payment will not be rendered until a claim is submitted.

7. **CLAIMS SUBMISSION:** We will submit your claims and assist you in any way we can to help get your claims paid. Your insurance plan may request information directly from you. Your failure to timely comply to your insurance plan's request may result in your claim denial and if so, will result in our seeking full reimbursement from you for services rendered, even if we are a participating provider with your plan. Your insurance benefit is a contract between you and your insurance plan. Once your claim has been billed, you will receive and explanation of benefits (EOB) reflecting payments made on your claim. Please review the EOB for payment summary. Should you receive a statement from Mid-Florida Prosthetic & Orthotics after your claim has been paid by insurance, please contact the location of your visit.
8. **SELF-PAY:** If you do not have valid health care coverage, you will be considered self-pay. Payment in full is due at the time of service unless prior arrangements have been made.
9. **PAYMENT METHODS:** We accept cash, personal checks, money orders, cashier's check, MasterCard, Visa and Discover and CareCredit as payment for services rendered.
10. **RETURNED CHECKS:** A returned check fee of $35 will be added to your account for every check returned for insufficient funds, stopped payment, or closed accounts. After the second occurrence, only cash, money orders, cashier's check or credit card payments will be accepted.
11. If for any reason my insurance company releases pay to me, I agree to sign over full payment to Mid-Florida Prosthetics & Orthotics. Further, I agree to may all costs incurred to collect a past due balance including but not limited to reasonable attorney fees, filing fees, collection agency fees, etc.

*****Knowing your insurance benefits is your responsibility. Please contact your insurance plan with questions you may have regarding your coverage*****

This is an agreement between Mid-Florida Prosthetic & Orthotics and the patient/responsible party signed below. By executing this agreement, you are agreeing to pay for all services that are receive.

I HAVE READ AND UNDERSTAND THE PAYMENT POLICY AND AGREE TO ABIDE BY ITS GUIDELINES

Printed Name: _____

Signature: _____

Date:_____