Anew Life Prosthetics and Orthotics

6438 Woodward Avenue, Detroit, MI 48202-3216 / Phone 313-870-9610 Fax 313-870-9620

Patient Registration

Mr/Mrs/Ms/Miss _____ Date of Birth: _____

Address: _____ Male ____ Female ____

City, State, ZIP _____ SSN: _____

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

Email: _____

How were you referred to us? _____

Emergency Contact:

Name: _____ Relation: _____ Phone: _____

Was your injury work or accident related? If so, give accident date, name and phone number of adjuster w/claim #

Are you any of the following: diabetic / in hospice care / resident of nursing home? Yes____ No____

Marital Information: Single _____ Married ____ Divorced _____ Widowed _____

Referring Physician name and phone: _____

Primary Care Physician name and phone: _____

Insurance Information:

Primary Insurance: _____

Phone/fax: _____

Member ID/claim#: _____

Secondary Insurance: _____

Phone/fax: _____

Member/claim# _____

Please provide copy of driver license, insurance card and credit card

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.

CONTINUED ON SECOND PAGE

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, parent/guardian if minor

Patient Name: _____ **is physically or mentally (circle) unable to sign**

Signature: _____ **Date:** _____

Representative

Representative Name (Print): _____

Representative Address: _____

_____

Representative Relationship: _____

Credit Card/Care Credit#: _____ **Revised 1/11/2019**

Bank account name, number _____ / Routing #_____

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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) 870-9620

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, parent/ or guardian if minor

If unable to sign:
Patient Name: _____ **(Please print)**
Signature by: _____ Date: _____
Representative

Representative Name: _____
Representative Address: _____
Representative Relationship: _____
(Please print)

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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 AHC 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 indebteness to the above, and I have to pay, in a current manner, 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 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 to you with the other required documents.

A photo copy of this agreement shall be considered as effective and valid as the original.

Signature: _____ **Date:** _____

Self, parent/ or guardian if minor

Patient Name: _____ **patient is physically or mentally (circle) unable to sign**

Signature by: _____ **Date:** _____

Representative Name/Relationship: _____ **(Print)**

Representative Address:

Patient Notice of Financial Responsibility

Out of Pocket Expenses

As part of our commitment of service to you, we will make every attempt to verify your insurance benefits at the time your services are rendered. However, **insurance verification or authorization is not a guarantee of insurance payment.** This only allows our office to provide you with a preliminary estimate of any monies due by the insured at the time of delivery of the device. Your patient portion is subject to change based on final claim determination by your insurance carrier. **You are responsible for notifying us of any changes in your insurance.**

Out of pocket expenses are contractual obligations with your insurance company. You are required to pay these services at the time of each visit. Out of pocket expenses may include, but are not limited to:

- Co pays on home visits
- Deductibles/co-insurance cost
- Non-covered services
- Forms that need to be completed by your physician

If you cannot make your required out of pocket payments, we reserve the option to reschedule or cancel your appointment

Should your insurance not cover the services provided, the balance is your responsibility.

We understand that medical costs can be overwhelming. At Anew Life Prosthetics and Orthotics we will do what we can to keep your medical costs down.
Unfortunately, we cannot have one set fee for your visit. Your insurance plan determines financial responsibility according to the level of service provided. We cannot quote you what your charges will be before you see the practitioner.

Payment is expected in full at the time of service.

We offer several payment options, including check, money order, credit / debit card, and CareCredit.

Cancellation and No-Show Policy

At Anew Life Prosthetics and Orthotics ("Anew Life"), our goal is to provide quality medical care in a timely manner. "No-shows" and late cancellations inconvenience those individuals who need access to timely medical care. This policy enables us to better utilize available appointments for our patients in need of medical care.

Cancellation of an Appointment:

In order to be respectful of the medical needs of other patients, please be courteous and call Anew Life promptly if you are unable to show up for an appointment. We understand that things come up and it may not be possible for you to keep your scheduled appointment. However, **if it is necessary to cancel your scheduled appointment, we ask that you call as soon as you know you will not be able to make it.** Appointments are in high demand and if you give us more than 24 hours notice, your early cancellation will give us a chance to reallocate the appointment slot to someone who is in need of treatment. If you give us less than 24 hours notice (late cancellation), we will likely not have time to fill the empty slot.

How to Cancel Your Appointment:

To cancel an appointment, please call 313-870-9610. If you do not reach the receptionist, you may leave a detailed message on our voicemail. If you would like to reschedule your appointment, please leave your phone number. We will return your call and give you the next available appointment time.

Late Cancellation and No-Show Policy:

A cancellation is considered late when a patient contacts Anew Life to cancel their scheduled appointment with less than 24-hours advance notice.

A "no-show" is determined when a scheduled patient misses their appointment without contacting Anew Life. A failure to be present at the time of a scheduled appointment without a call cancelling the appointment will be recorded in your medical record as a "no-show".

- First no-show: **$25** (will be billed to your account)
- Second late cancellation or no-show: **$25.00 Fee** (will be billed to your account)
- Third late cancellation or no-show: **$50.00 Fee** (will be billed to your account and you will not be rescheduled until all fees are paid).

ANEW LIFE
Prosthetics and Orthotics

Your financial responsibility depends on the following factors:.

If you have:	You are responsible for:	Anew will:
Insurance Plan with whom we have a contract	If the services you receive are covered by the plan: patient portion 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 your eligibility, benefit information and patient portion (if applicable) as well as obtain prior authorization (if applicable).
No Insurance	Payment in full due on or before date of delivery.	Advise you regarding charges for services provided.

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.

We require: 50% down with balance due at delivery. Returned check fee: $45.00 or state maximum, if less.

CREDIT CARD ON FILE POLICY

At Anew Life Prosthetics and Orthotics, LLC, we require keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable. Without this authorization, a billing fee of $25 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 charge for each month that the bill remains unpaid.

Your credit card information is kept confidential and secure and 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, LLC 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 _____ / _____ / _____

Cardholder Name _____

Signature _____

Billing Address _____

City _____ **State**_____ **Zip** _____

I (we), the undersigned, authorize and request [practice name] 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 [practice name].

This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60 day notification to [practice name] in writing and the account must be in good standing.

Patient Name (Print): _____

Patient Signature: _____ **Date:** _____ / _____ / _____

Anew Life Prosthetics and Orthotics LLC
6438 Woodward Avenue Detroit, MI 48202
P: 313-870-9610 F: 313-870-9620

HIPAA Documents and Supplier Standards Receipt

I, _____, have received the following document(s) on

_____/_____/_____, and I agree to the terms listed within them:

Document Name	Description
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.
Bill of Rights and Responsibilities	Patient rights and responsibilities with Anew Life Prosthetics and Orthotics LLC providing service(s)/item(s).
Credit Card Policy	Credit Card policy and form kept in patient file.
Financial Assistance	Local agencies who offer assistance for prosthetic patients.
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 Release Form	Medical Release of Information form where all fields are completed by patient.
Medicare Standards	Mandated federal standard policies and procedures applicable.
Registration Form	Patient Registration Form where all fields are completed by patient.

_____ _____

Signature Date

Notice of Confidentially: This document contains unconditionally private medical records. Any improper use of the information contained herein constitutes a breach of patient medical confidentiality.