Mid-Florida Prosthetics & Orthotics

PROVIDER FOR THE FOLLOWING INSURANCE COMPANIES:

- ABP
- ADVANTAGE CARE
- AETNA
- AVMED
- BLUECROSS BLUE SHIELD (*NON MEDICARE PLAN*)
- CARE PLUS
- CHILDREN'S MEDICAL SERVICE
- CYPRESS CARE
- DEPARTMENT OF LABOR
- DMENSION
- FIRST HEALTH (HOMELINK)
- FREEDOM
- HEALTHEASE
- HME
- HUMANA
- MEDICAID
- MEDICARE
- MEDICARE COMPLETE
- MSC
- NORTHWOOD
- PED-I-CARE
- PHYSICIANS UNITED PLAN
- PREFERRED CARE PARTNERS
- PROGRESSIVE MEDICAL (***NON AUTO***)
- SECURE HORIZONS
- TECH HEALTH
- TOTAL MEDICAL
- TODAY'S OPTIONS
- TRICARE
- UMR
- UNITED HEALTHCARE
- VETERANS ADMINISTRATION
- VISTA
- VOCATIONAL REHAB
- WELLCARE MEDICAID (***NON MEDICARE***)
- **accepting most major credit cards**

Ocala	*2300 SE 17th Street • Ocala, FL 34471 • Tel: 352-351-3207 Fax: 352-351-3267*
Gainesville	*6608 NW 9th Blvd • Gainesville, FL 32605 • Tel: 352-331-3399 Fax: 352-331-9927*
Leesburg	*601 E. Dixie Hwy. Suite 806 • Leesburg, FL 34748 • Tel: 352-435-4500 Fax 352-435-4516*
Lake City	*757 West Duval St • Lake City, FL 32055 • Tel: 386-755-5774 Fax: 386-755-5785*

Mid-Florida Prosthetics & Orthotics

Acknowledgment of receipt of Notice of Privacy Practices
and
Authorization to release medical record information and permit payment to:

M&M Rehab, Inc. dba Mid-Florida Prosthetics & Orthotics

I certify that I have received a copy of M&M Rehab., Inc.'s Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills, or in the performance of M&M Rehab., Inc.'s health care operations. The Notice of Privacy Practices also descries my rights and M&M Rehab., Inc.'s duties with respect to my PHI. The Notice of Privacy Practices is posted in the lobby and is also available from our receptionist.

M&M Rehab., Inc. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the offices and requesting one be sent in the mail or by asking for one at the time of my next appointment

I authorize Dr. ______________________ to release a copy of my medical records to M&M Rehab., Inc. d/b/a Mid-Florida Prosthetics & Orthotics, hereinafter referred to as "Mid-Fla." I further authorize Mid-Fla. to release to my insurer any information as required for payment determination on all claims. I request that payment of authorized benefits, made on my behalf for the medical equipment provided by Mid-Fla., be assigned and made payable to Mid-Fla. or its affiliates. Although, I recognize I have the primary responsibility for contacting and submitting claims to my insurer - I authorize Mid-Fla. to submit any claim to any of the insurers as may be required.

I understand that I am responsible for any deductibles, co-payments, or NON-COVERED items. Should my insurance not provide payment in its entirety, for any reason, I understand I am responsible. In addition, if my insurance company should, for any reason, release payment to me I agree to sign over full payment to Mid-Fla. Further, I agree to pay all costs incurred to collect any past due balance, including, but not limited to, reasonable attorneys' fees, filing fees, etc.

Signature of Patient: ____

Date

Print name ____

Signature of Responsible Party: ____
(if patient is a minor)

Date

Responsible party's SS# ___________________________ Date of Birth _____/______/ _____________________

Print name ____

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Summary of
NOTICE OF PRIVACY PRACTICES
For M&M REHAB, INC.

This summary briefly describes important information contained in our Notice of Privacy Practices. We encourage you to take the time to read the complete notice.

Our Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information.

Your "protected health information" means any of your written and oral health information, including your demographic data that can be used to identify you. This health information is created or received by your health care provider, and relates to your past, present, or future physical or mental health or condition.

This notice will let you know about the various ways we use and disclose your medical information, describe your rights and our obligations with respect to the use or disclosure of your medical information.

We will also ask that you acknowledge receipt of this notice the first time you come to or use any of our facilities, because the law requires us to make a good faith effort to obtain your acknowledgment.

We are required by law to:

Make sure that any medical or health information that we have that identifies you is kept private and will be used or disclosed only in accord with our Notice of Privacy Practices and applicable law;

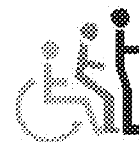
Give you the complete notice of our legal duties and our privacy practices; and

Abide by the terms of the Notice of Privacy Practices that is in effect at the present time.

PLEASE KEEP THIS COPY FOR YOUR RECORDS.

Mid-Florida Prosthetics & Orthotics

Visit us at www.midflpros.com



PATIENT INFORMATION SHEET

1. Patient Name: ______________________ ❑ Male ❑ Female
2. Address ______________________
   City ______________________ State ________ Zip ________
3. Date of birth ____/____/_____ SS# ____________ Driver's Lic# ______________ St___
4. ❑ Single ❑ Married ❑ Other ____________ Spouse's name ______________
5. Home phone ______________ Work phone ______________
   Mobile ______________ Email ______________
6. Alternate address ______________________
   City ______________________ State ________ Zip ________
7. ❑ Employed ❑ Full time student
8. Employer/School ______________________
9. Referring physician/patient______________________
10. Diagnosis / Injury______________________ Date of Injury _____/_____/_______

PRIMARY INSURANCE INFORMATION

11. Insured party's name ______________________ DOB ____/____/______ Age _____
12. Sex ___ Address ______________________ City ____________ St _____ Zip _______
13. Phone (   ) ____________ SS# ____________ Driver's Lic# ______________ St___
14. Employer's name ______________________
15. Address ______________________ City ____________ St _____ Zip _______
16. Insurance plan/program name ______________________
17. Policy ID# ______________________ Group # ______________________

SECONDARY INSURANCE INFORMATION

❑ NONE

18. Insured party's name ______________________ DOB ____/____/______ Age _____
19. Sex ___ Address ______________________ City ____________ St _____ Zip _______
20. Phone (   ) ______________________ SS# ______________________
21. Employer's name ______________________
22. Address ______________________ City ____________ St _____ Zip _______
23. Insurance plan/program name ______________________
24. Policy ID# ______________________ Group # ______________________

Mid-Florida Prosthetics & Orthotics

Please review the following list and check the boxes next to any items you have received, then sign and date the bottom of this form. If you have NOT received any of these items, please just sign and date this form.

Thank You.

Any items received within the past 5 years?

- ☐ Leg/Knee Brace
- ☐ Ankle/Foot Brace
- ☐ Arm Prosthesis
- ☐ Leg Prosthesis
- ☐ Foot Prosthesis

Any items received with the past 3 years?

- ☐ Shoulder Brace
- ☐ Wrist Brace
- ☐ Back Brace
- ☐ Hip Brace

Any items received within the past year?

- ☐ Head/Neck brace
- ☐ Clavicle Splint
- ☐ Finger Splint
- ☐ Prosthetic Shrinker
- ☐ Prosthetic Socks
- ☐ Prosthetic Liners
- ☐ Prosthetic Sheaths

Have you received shoes and or inserts this calendar year? ☐ Yes ☐ No

If so, when? ________________________

If you are diabetic please list the doctor who treats you for your diabetes.

____

______________________________________ ________________________

Signature Date

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Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Supplier Standards

Below is an abbreviated version of the supplier standards every Medicare DMEPOS supplier must meet in order to obtain and retain 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. An authorized individual (one whose signature is binding) must sign the application for billing privileges.
4. A supplier must fill orders from its own inventory, or must contract with other companies for the purchase of items necessary to fill the order. A supplier may not contract with any entity that is currently excluded from the Medicare program, any State health care programs, or from any other Federal procurement or no 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.
8. A supplier must permit CMS, or its agents to conduct on-site inspections to ascertain the supplier's compliance with these standards. The supplier location must be accessible to beneficiaries during reasonable business hours, and must maintain a visible sign and posted hours of operation.
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 or cell phone 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 must agree not to initiate telephone contact with beneficiaries, with a few exceptions allowed. This standard prohibits suppliers from calling beneficiaries in order to solicit new business.
12. A supplier is responsible for delivery and must instruct beneficiaries on use of Medicare covered items, and maintain proof of delivery.
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 directly, or through a service contract with another company, 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 supplier standards to each beneficiary to whom it supplies a Medicare-covered item.
17. A supplier must disclose to the government 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 implementing 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 of 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.

______________________________ I have received a copy of the above.

______________________________ Date

(352) 351-3207 (352) 331-3399 **M & M Rehab., Inc.** (386) 755-5774 (352) 435-4500