ACHILLES
PROSTHETICS AND ORTHOTICS

PATIENT ADVISEMENT

- Patients are responsible for all fees, regardless of insurance coverage. Patient financial responsibility is due at the time of service. This includes the patient deductible, co-payments and co-insurance.

- Due to the volume of our business, anyone who is 10 or more minutes late for an appointment may have to be rescheduled

- Appointments not rescheduled or cancelled less than 24 business hours in advance may be subject to a missed appointment fee of $25.

- We respectfully request that non-English speaking patients bring an English speaking adult interpreter with them to their appointment.

- Please have all of your insurance information with you. All insurances must be verified prior to your appointment with the practitioner.

Thank you for your cooperation!

BAKERSFIELD: 2624 "F" Street, Bakersfield, CA 93301 PH. (661) 323-5944 FAX (661) 323-2820
SAN LUIS OBISPO: 842 California Blvd., San Luis Obispo, CA 93401 PH. (805) 541-3800 FAX (805) 541-3818
SANTA MARIA: 622 East Main Street, Santa Maria, CA 93454 PH. (805) 925-6144 FAX (805) 925-2746

ACHILLES
PROSTHETICS AND ORTHOTICS

NOTICE OF PATIENT FINANCIAL RESPONSIBILITY

Our office provides services in good faith that it will be appropriately compensated. It is the patients/guarantor's responsibility to understand their individual health policy and its coverage.

Our office will gladly file with your primary and secondary health insurance on your behalf; but requires that patient deductible, copayments & coinsurance be paid at the time of service.

Patients are responsible for letting us know of any changes in insurance coverage or other pertinent demographic information. You must provide our office with a copy of your current insurance card(s) as well as a state issued photo ID or driver's license.

We will coordinate with your employer for work related injuries. It is the patient's responsibility to let us know if a visit is work related.

We **do not** coordinate with third party liability *(example: auto accidents, school insurance)*. When a third party is involved, patients are considered self pay. It is your responsibility to inform us in writing if your visit is the result of a third party liability. If claims are erroneously filed to your health insurance or retroactively reversed, then the liability becomes that of the patient/guarantor.

Interest, penalties, collection costs & legal costs incurred in order to obtain patient payment becomes the responsibility of the patient/guarantor.

Patients are expected to honor their scheduled appointment times. Missed appointments, appointments not rescheduled or cancelled less than 24 business hours in advance may be subject to a **missed appointment fee of $25**. Missed appointment fees are not covered by insurance and are the full responsibility of the patient/guarantor. Multiple missed appointments may result in dismissal as a patient.

_____
Patient Name

_____ _____
Patient/Guarantor Signature Date Date

BAKERSFIELD: 2624 "F" Street, Bakersfield, CA 93301 PH. (661) 323-5944 FAX (661) 323-2820
SAN LUIS OBISPO: 842 California Blvd., San Luis Obispo, CA 93401 PH. (805) 541-3800 FAX (805) 541-3818
SANTA MARIA: 622 East Main Street, Santa Maria, CA 93454 PH. (805) 925-6144 FAX (805) 925-2746

ACHILLES
PROSTHETICS AND ORTHOTICS

PATIENT INFORMATION SHEET

Today's Date_____

Is this Workers Compensation? Y N

Date of Injury_____

PLEASE PRINT FOR BILLING PURPOSES, WE REQUIRE THIS FORM TO BE FULLY COMPLETED.

PATIENT INFORMATION

Name: _____ Nickname: _____

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

Marital Status: □ Single □ Married □ Divorced □ Widowed Driver's License/State ID#: _____

Address: _____ APT #: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Employer: _____ Occupation: _____

Address: _____ Phone: _____

Name of Spouse/Responsible Party: _____ Home Phone: _____

DOB: _____ Employer: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Emergency Contact: _____ **Relationship:** _____

Address: _____ Phone: _____

Who is your primary care doctor? _____

Who referred you to our office? _____

INSURANCE INFORMATION

	PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance name:	_____	_____
Subscriber's name:	_____	_____
	SELF~SPOUSE~PARENT	SELF~SPOUSE~PARENT
Subscriber's SSN#:	_____	_____
Subscriber's DOB:	_____	_____
ID/Policy#:	_____	_____
Group #:	_____	_____
	□ PPO □ EPO □ HMO	□ PPO □ EPO □ HMO
	NAME OF PMG: _____	NAME OF PMG: _____

The patient is responsible for all fees, regardless of insurance coverage. Patient's financial responsibility is due at time of service. This includes deductible, copayments and coinsurance.

AUTHORIZATION AND ASSIGNMENT

I hereby authorize Achilles Prosthetics and Orthotics to furnish information to insurance carriers concerning my illnesses and treatments and I hereby assign to the above mentioned firm all payments for medical services rendered.

Patient/ Guardian Signature _____

PLEASE COMPLETE OTHER SIDE.

Guardian Name (please print) _____

MEDICAL HISTORY

Height: _____ Weight: _____ Recent weight changes? No: ☐ Yes: ☐ How much? _____

Have you had or do you currently have the following:

Heart Problems:	☐	Hepatitis C:	☐	Alzheimer Disease:	☐
Heart Attack:	☐	Syphilis:	☐	Nervous Breakdown:	☐
Hypertension:	☐	HIV Positive:	☐	Psychiatric Problems:	☐
Vascular Disease:	☐	Rheumatoid Arthritis:	☐	Alcoholism:	☐
Stroke:	☐	Obesity:	☐	Pacemaker/Defibrillator:	☐
Diabetes:	☐	Osteoarthritis:	☐	Seizure Disorder:	☐
Kidney Disease:	☐	Pulmonary Disease (TB):	☐	Hearing Loss:	☐
Osteoporosis:	☐	Vision Problems:	☐	Currently Pregnant:	☐
Hepatitis A or B:	☐	Parkinson Disease:	☐	MRSA:	☐
Tuburculosis:	☐	Gout:	☐		
Ulcer:	☐	Known Allergies:	_____		

List any other conditions that you feel may affect your treatment: (Include dates and describe surgeries)

_____

_____

_____

Are you currently taking medication? No: ☐ Yes: ☐ If so, please list: _____

_____

_____

Amputation: No: ☐ Yes: ☐ Where and which side? _____

Have you ever seen an orthotist/prosthetist before? No: ☐ Yes:☐ If yes, please list:

Name: _____ Date: _____

Have you ever had any orthotics/prosthetics provided before? No: ☐ Yes: ☐ If yes, please list:

Item: _____ Date: _____

Have you ever been hospitalized for other illnesses? No: ☐ Yes: ☐ If yes, please list: _____

_____

_____

HISTORY OF INJURY/ACCIDENT

Date of Injury: _____ Hour: _____AM or PM

Please describe how the injury/accident occurred: _____

_____

_____

Complaint: _____

_____

_____

Injury/accident occurred:

☐ On job: Adjuster's name: _____ Claim #: _____

☐ Traffic Accident

☐ School: _____

☐ At home

☐ Other: _____

ACHILLES
PROSTHETICS AND ORTHOTICS

NOTICE OF HIPAA & PRIVACY PRACTICES

Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal statute which, among other things, sets up a framework for protecting patient identifiable health information, referred to as Protected Health Information (PHI). This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our business associates and their subcontractors, may use and disclose your 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 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 purposes of providing health care services to you, to pay your health care bills, to support the operation of the practitioner's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred, DME vendors, surgery centers/hospitals, referring physicians, family practitioner, physical therapists, home health providers, laboratories, workers' compensation adjusters, nurse case managers, etc. to ensure that the health care provider 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, surgery, MRI or other diagnostic test, injection procedures, injection series, physical therapy, etc., may require that your relevant protected health information be disclosed to your health plan to obtain approval for the procedure.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your practitioner. 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, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in. 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, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates and other required uses and disclosures. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

You may revoke the 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

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Pursuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is

related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or another person, or information that was obtained under a promise of confidentiality.

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 health 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 practitioner is not required to agree to your requested restriction except if you request that the practitioner not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request confidential communications - You have the right to request confidential communication from us by alternative means or at an alternate 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 request an amendment to 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 – You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

You have the right to receive notice of a breach – We will notify you if your unsecured protected health information has been breached.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make copies of our new notice if you wish to obtain one.

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 our **HIPAA compliance officer, Daniel J. Newton, CP** at (661) 323-5944. **We will not retaliate against you for filing a complaint.**

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. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with a member of our office staff in person or by phone at the main number of your providing office.

BAKERSFIELD

2624 "F" Street, Bakersfield, CA 93301 PH. (661) 323-5944 FAX (661) 323-2820

SAN LUIS OBISPO

842 California Blvd., San Luis Obispo, CA 93401 PH. (805) 541-3800 FAX (805) 541-3818

SANTA MARIA

622 East Main Street, Santa Maria, CA 93454 PH. (805) 925-6144 FAX (805) 925-2746

TEMPLETON

234 Heather Ct. Ste. 101, Templeton, CA 93465 PH. (805) 434-1600 FAX (805) 434-1603

NAME_____ DOB_____

PAYMENT OF AUTHORIZED MEDICARE BENEFITS

I request that payment of authorized Medicare benefits be made either to me or on my behalf to *Achilles Prosthetics & Orthotics, Inc.,* for any services furnished me by that supplier. I authorize any holder of medical information about me to release to The Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If Item-9 of the CMS-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Beneficiary Signature *Date*

Medicare Secondary Payer (MSP) Questionnaire

Beneficiary Name:_____ Date:_____

PART I

1. Are you receiving Black Lung (BL) Benefits?
___ Yes; Date benefits began: _____*MM/DD/CCYY*
BL IS PRIMARY PAYER ONLY FOR CLAIMS RELATED TO BL.
___ No.
2. Are the services to be paid by a government *research* program?
___ Yes.
GOVERNMENT RESEARCH PROGRAM WILL PAY PRIMARY BENEFITS FOR THESE SERVICES.
___ No.
3. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for *your* care at this facility?
___ Yes.
DVA IS PRIMARY FOR THESE SERVICES.
___ No.
4. Was the illness/injury due to a work-related accident/condition?
___ Yes; Date of injury/illness: _____*MM/DD/CCYY*
Name and address of workers' compensation plan (WC) plan:

_____
_____
_____

Policy or identification number: _____
Name and address of your employer:

_____
_____
_____

WC IS PRIMARY PAYER ONLY FOR CLAIMS FOR WORK-RELATED INJURIES OR ILLNESS, GO TO PART III.
___ No. **GO TO PART II.**

PART II
1. Was illness/injury due to a non-work-related accident?
___ Yes; Date of accident: _____*MM/DD/CCYY*
___ No. GO TO PART III
2. Is no-fault insurance available? (No-fault insurance is insurance that pays for health care services resulting from injury to you or damage to your property regardless of who is at fault for causing the accident.)
___Yes. Name and address of no-fault insurer(s) and no-fault insurance policy owner:

_____
_____
_____

Insurance claim number(s): _____
___No.
3. Is liability insurance available? (Liability insurance is insurance that protects against claims based on negligence, inappropriate action or inaction, which results in injury to someone or damage to property.)
___Yes.
Name and address of liability insurer(s) and responsible party:

_____
_____
_____

Insurance claim number(s): _____
___No.

NO-FAULT INSURER IS PRIMARY PAYER ONLY FOR THOSE SERVICES RELATED TO THE ACCIDENT. LIABILITY INSURANCE IS PRIMARY PAYER ONLY FOR THOSE SERVICES RELATED TO THE LIABLITY SETTLEMENT, JUDGMENT, OR AWARD. GO TO PART III.

PART III

1. Are you entitled to Medicare based on:

___ Age. **Go to PART IV.**
___ Disability. **Go to PART V.**
___ *End-Stage Renal Disease (*ESRD*)*. **Go to PART VI.**

Please note that both "Age" and "ESRD" OR "Disability" and "ESRD" may be selected simultaneously. An individual cannot be entitled to Medicare based on "Age" and "Disability" simultaneously. Please complete ALL "PARTS" associated with the patient's selections.

PART IV – AGE

1. Are you currently employed?

___ Yes.
Name and address of your employer:

_____
_____
_____

___ No. *If applicable, d*ate of retirement: _____MM/DD/CCYY
___*No. Never Employed.*

2. *Do you have a spouse who is* currently employed?

___ Yes.
Name and address of your *spouse's* employer:

_____
_____
_____

___ No. *If applicable, d*ate of retirement: _____MM/DD/CCYY
___*No. Never Employed.*

***IF THE PATIENT ANSWERED "NO" TO BOTH QUESTIONS 1 AND 2, MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED "YES" TO QUESTIONS IN PART I OR II. DO NOT PROCEED FURTHER.**

3. Do you have group health plan (GHP) coverage based on your own or a spouse's current employment?

___ Yes, *both.*
___ *Yes, spouse.*
___ *Yes, self.*
___ No. **STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO THE QUESTIONS IN PART I OR II.**

4. *If you have GHP coverage based on your own current employment, d*oes *your* employer that sponsors *or contributes to the* GHP employ 20 or more employees?

___ Yes. **GHP IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.**
Name and address of GHP:

_____
_____
_____

Policy identification number *(this number is sometimes referred to as the health insurance benefit package number)*: _____
Group identification number: _____
Membership number (prior to the Health Insurance Portability and Accountability Act (HIPAA), this number was frequently the individual's Social Security Number (SSN); it is the unique identifier assigned to the policyholder/patient): _____
Name of policyholder*/named insured*: _____
Relationship to patient: _____
___ No.

5. If you have GHP coverage based on your spouse's current employment, does your spouse's employer, that sponsors or contributes to the GHP, employ 20 or more employees?

___ *Yes.* **GHP IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.**
Name and address of GHP:

_____
_____
_____
Policy identification number (this number is sometimes referred to as the health insurance benefit package number): _____ *Group identification number:* _____
Membership number (prior to HIPAA, this number was frequently the individual's SSN; it is the unique identifier assigned to the policyholder/patient): _____
Name of policyholder/named insured: _____
Relationship to patient: _____
___ *No.*

***IF THE PATIENT ANSWERED "NO" TO BOTH QUESTIONS 4 AND 5, MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED "YES" TO QUESTIONS IN PART I OR II.**

PART V – DISABILITY
1. Are you currently employed?
___ Yes.
Name and address of your employer:

_____
_____
_____
___ No. *If applicable, d*ate of retirement: _____*MM/DD/CCYY*
___*No. Never Employed.*
2. *Do you have a spouse who is* currently employed?
___ Yes.
Name and address of your *spouse's* employer:

_____
_____
_____
___ *No. If applicable, date of retirement:* _____*MM/DD/CCYY*
___*No. Never Employed.*
3. Do you have group health plan (GHP) coverage based on your own or a *spouse's* current employment?
___ Yes, *both.*
___ *Yes, self.*
___ *Yes, spouse.*
___ No.
4. Are you covered under the GHP of a family member other than your spouse?
_____*Yes.*
Name and address of your family member's employer:

_____
_____
_____
_____*No.*

***IF THE PATIENT ANSWERED "NO" TO QUESTIONS 1, 2, 3, AND 4, STOP. MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED "YES" TO QUESTIONS IN PART I OR 11.**

5. *If you have GHP coverage based on your own current employment, does your* employer that sponsors *or contributes to the* GHP employ 100 or more employees?
___ Yes. **GHP IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.**
Name and address of GHP:

_____
_____
_____
Policy identification number *(this number is sometimes referred to as the health insurance benefit package number)*: _____
Group identification number: _____

Membership number (prior to HIPAA, this number was frequently the individual's SSN; it is the unique identifier assigned to the policyholder/patient): _____
Name of policyholder/*named insured*: _____
Relationship to patient: _____
___ No.
6. If you have GHP coverage based on your spouse's current employment, does your spouse's employer, that sponsors or contributes to the GHP, employ 100 or more employees?
___ *Yes.* **GHP IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.**
Name and address of GHP:

_____
_____
_____
Policy identification number (this number is sometimes referred to as the health insurance benefit package number): _____
Group identification number: _____
Membership number (prior to HIPAA, this number was frequently the individual's SSN; it is the unique identifier assigned to the policyholder/patient): _____
Name of policyholder/named insured: _____
Relationship to patient: _____
___ *No.*
7. If you have GHP coverage based on a family member's current employment, does your family member's employer, that sponsors or contributes to the GHP, employ 100 or more employees?
___ *Yes.* **GHP IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.**
Name and address of GHP:

_____
_____
_____
Policy identification number (this number is sometimes referred to as the health insurance benefit package number): _____
Group identification number: _____
Membership number (prior to HIPAA, this number was frequently the individual's SSN; it is the unique identifier assigned to the policyholder/patient): _____
Name of policyholder/named insured: _____
Relationship to patient: _____
___ *No.*

***IF THE PATIENT ANSWERED "NO" TO QUESTIONS 5, 6, and 7, MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED "YES" TO QUESTIONS IN PART I OR II.**

PART VI – ESRD
1. Do you have group health plan (GHP) coverage?
___ *Yes.*
IF APPICABLE, YOUR GHP INFORMATION:
*N*ame and address of GHP:

_____
_____
_____
Policy identification number *(this number is sometimes referred to as the health insurance benefit package number*: _____
Group identification number: _____
Membership number (prior to HIPAA, this number was frequently the individual's SSN; it is the unique identifier assigned to the policyholder/patient): _____
Name of policyholder */named insured*: _____
Relationship to patient: _____
Name and address of employer, if any, from which you receive GHP coverage:

_____
_____
_____

IF APPICABLE, YOUR SPOUSE'S GHP INFORMATION:
Name and address of GHP:

_____
_____
_____
Policy identification number (this number is sometimes referred to as the health insurance benefit package number: _____
Group identification number: _____
Membership number (prior to HIPAA, this number was frequently the individual's SSN; it is the unique identifier assigned to the policyholder/patient): _____
Name of policyholder /named insured: _____
Relationship to patient: _____
Name and address of employer, if any, from which your spouse receives GHP coverage:
IF APPICABLE, YOUR FAMILY MEMBER'S GHP INFORMATION:
Name and address of GHP:

_____
_____
_____
Policy identification number (this number is sometimes referred to as the health insurance benefit package number: _____
Group identification number: _____
Membership number (prior to HIPAA, this number was frequently the individual's SSN; it is the unique identifier assigned to the policyholder/patient): _____
Name of policyholder /named insured: _____
Relationship to patient: _____
Name and address of employer, if any, from which your family member receives GHP coverage:

_____
_____
_____
___ No. **STOP. MEDICARE IS PRIMARY.**
2. Have you received a kidney transplant?
___ Yes. Date of transplant: _____*MM/DD/CCYY*
___ No.
3. Have you received maintenance dialysis treatments?
___ Yes. Date dialysis began: _____*MM/DD/CCYY*
If you participated in a self-dialysis training program, provide date training started:
_____*MM/DD/CCYY*
___ No.
4. Are you within the 30-month coordination period *that starts MM/DD/CCYY? (The 30-month coordination period starts the first day of the month an individual is eligible for Medicare (even if not yet enrolled in Medicare) because of kidney failure (usually the fourth month of dialysis). If the individual is participating in a self-dialysis training program or has a kidney transplant during the 3-month waiting period, the 30-month coordination period starts with the first day of the month of dialysis or kidney transplant.)*
___ Yes.
___ No. **STOP. MEDICARE IS PRIMARY.**
5. Are you entitled to Medicare on the basis of either ESRD and age or ESRD and disability?
___ Yes.
___ No.
6. *Was your initial entitlement to Medicare (including simultaneous or dual entitlement) based on ESRD?*
___ Yes. **STOP. GHP CONTINUES TO PAY PRIMARY DURING THE 30-MONTH COORDINATION PERIOD.**
___ No. **INITIAL ENTITLEMENT BASED ON AGE OR DISABILITY.**
7. Does the working aged or disability MSP provision apply (i.e., is the GHP *already primary* based on age or disability entitlement)?
___ Yes. ***GHP CONTINUES TO PAY PRIMARY DURING THE 30-MONTH COORDINATION PERIOD.***
___ No. **MEDICARE CONTINUES TO PAY PRIMARY.**

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.

ACHILLES
PROSTHETICS AND ORTHOTICS

PROSTHETICS AND ORTHOTICS
WARRANTY INFORMATION & RETURN POLICY

Orthotic custom products carry a 60 day defective parts and labor warranty. Pre-fabricated orthotic products carry a 30 day defective parts and labor warranty. Prosthetic products carry a 6-month defective parts and labor warranty. Achilles Prosthetics and Orthotics will also honor any manufacturer (parts) warranty that applies to any product we provide to the patient. Achilles Prosthetics and Orthotics will notify all Medicare beneficiaries of the warranty coverage and we will honor all warranties under applicable law. Achilles Prosthetics and Orthotics will repair or replace, free of charge, Medicare-covered equipment that is under warranty. In addition, an owner's manual with warranty information will be provided to beneficiaries for all durable medical equipment where this manual is available.

Achilles Prosthetics & Orthotics, Inc. will accept returns of substandard *(less than full quality for a particular item)* or unsuitable items *(inappropriate for the beneficiary at the time it was fitted or sold)* from beneficiaries as determined by a consensus of beneficiary and practitioner. Orthopedic products cannot be returned for any other reason. All warranties will be honored.

Mastectomy products *(Breast Forms, Bras, Camisoles, ETC.)* and orthopedic shoes *(including inserts)* are **NON- Returnable** **NON- Refundable** once the product has been fit and the product leaves the premises. The only exception to this is a verifiable manufacturer's defect that the manufacturer agrees to credit *Achilles Prosthetics and Orthotics Inc.*

I have read and understand the warranty coverage and return policy for the products I will be provided.

****All products ordered at patients request without a fitting are also NON-Returnable.****

Thank you,
Achilles Prosthetics & Orthotics Inc.

BAKERSFIELD: 2624 "F" Street, Bakersfield, CA 93301 PH. (661) 323-5944 FAX (661) 323-2820
SAN LUIS OBISPO: 842 California Blvd., San Luis Obispo, CA 93401 PH. (805) 541-3800 FAX (805) 541-3818
SANTA MARIA: 622 East Main Street, Santa Maria, CA 93454 PH. (805) 925-6144 FAX (805) 925-2746
TEMPLETON: 234 Heather Ct. Ste. 101, Templeton, CA 93465 PH. (805) 434-1600 FAX (805) 434-1603