

PATIENT AGREEMENT / DETAILED WRITTEN ORDER

For Billing: Please call 888-351-4524

Call _____ if you have questions, concerns, or suggestions about our equipment or service.

PATIENT INFORMATION

Female Male

Name _____
First M Last

Mailing Address _____

Hm # _____ City State Zip Wk # _____

DOB _____ SSN _____

EMAIL _____
(For Access To Payment Portal)

DETAILED WRITTEN ORDER

Verbal Order Date _____

Practitioner _____

NPI # _____

Phone # _____

ICD 10 _____

Practitioner Signature: _____ Date: _____

By my signature, I am prescribing the item(s) listed. In my judgment the prescribed item(s) is medically indicated, necessary and consistent with the current accepted standards of medical practice and treatment of patient's physical condition. A qualified individual has performed the proper fitting, adjustment and education of the product(s) with the patient.

Left Right Medicare Requires An Original Signature

MEDICARE

Primary Secondary

Medicare # _____

Name on Card _____

INSURANCE INFORMATION

Insurance Carrier _____

Insured's Name _____

Relationship to Patient _____

ID # _____

Benefits/Eligibility Phone # _____

Adjuster/Contact _____

DOI _____

COMMENTS:

Visa MC AMEX Discover Check # _____ Amount _____ CC Exp Date _____ CVC # _____

Card Holder _____ CC # _____ Billing Zip Code _____

AUTHORIZATION TO ASSIGN BENEFITS TO PROVIDER & RELEASE OF MEDICAL INFORMATION:

I give consent for treatment and request that payment of authorized Medicare and other benefits be made on my behalf to OTI for products and services that they have provided me. I further authorize a copy of this agreement to be used in place of the original and authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits of compliance with current healthcare standards. I have been provided my Bill of Rights & Responsibilities, privacy notice, Supplier Standards, how to reach OTI 24/7, instruction on proper use, troubleshooting, potential hazards of equipment, community resource and home safety information, rights to refuse treatment.

<input type="checkbox"/>	THESE HAVE BEEN VERIFIED:	<ul style="list-style-type: none"> • Proper Electrical Outlet • Hand Controller Accessible • Patient or caregiver has demonstrated competency in using the device 	<ul style="list-style-type: none"> • Patient Comfortable in Device • Switches Operable 	<ul style="list-style-type: none"> • Cord(s) Unobstructed • Device Working in Home 	<ul style="list-style-type: none"> • Proper Patient Kit Application • Secure Device Placement
	Comments:	Person Taught if other than Patient: _____			

Patient or Authorized Representative Signature _____ Date _____

Relationship to Patient / Reason for Signing _____

REP SIGNATURE	DELIVERED BY	PURCHASE / RENTAL DATE	FACILITY CODE
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White - OTI Copy

Pink - Patient Copy

MEDICARE: Primary Secondary

Surgery Date ____/____/____ CPM Applied Hosp Date ____/____/____

Hosp Discharge Date ____/____/____ SNF Discharge Date ____/____/____

PROTOCOL INFORMATION

CPM Type: Knee Shoulder Wrist Elbow Hand
 Ankle Other _____

Beginning ROM _____ Increase ROM _____

Frequency Hrs/Day _____ ROM Goal _____

Procedure _____

Lft Rt Bilateral Pre-Op Set-up

ORDER INFORMATION - ITEM 1

MANUFACTURER	OTI PART #	QTY.	PRICE EA.

ORDER INFORMATION - ITEM 2

MANUFACTURER	OTI PART #	QTY.	PRICE EA.

PATIENT BILL OF RIGHTS AND RESPONSIBILITIES

You have the right to:

- Receive service without regard to race, religion, color, age, gender, handicap, sexual orientation, veteran status or lifestyle
- Know maximum charges for services including fees covered by patient and those covered by insurance, third party, Medicare or Medicaid
- Be advised if charges increase from those stated at the time of service
- Receive clear instructions in the use of all products, equipment and protocols ordered by your physician
- Know the name and qualifications of the individual providing service
- Make informed decisions about services
- Receive services directly or through contract
- Refuse treatment, however, we will contact the referring provider prior to making that decision
- Know when and why equipment may be discontinued
- Be referred to another agency, if requested, for any reason
- Be treated in such a manner that is free from any type of abuse, neglect, damage to or theft of property, and exploitation of any kind
- Have your property treated with respect
- Know that OTI is a privately held corporation that maintains liability insurance
- Receive a response to a lodged complaint in regards to the investigation and resolution of the complaint
- I received the Community Resource, Emergency Prep, & Scope of Service Information.
- Express content, concern or dissatisfaction with any aspect of care, employees, products or equipment or any company related services by calling **Customer Service at 1-877-255-0052** (8:30 am - 5:00 p.m. CST Monday - Friday) Emergency Contact 24 hours/day, **CHAP** (Community Health Accreditation Program) at **1-800-656-9656** (8:00 am - 5:00 p.m. EST Monday - Friday), or contacting us in writing at:

OTI

P.O. Box 713

Des Moines, IA 50303

Your responsibilities include the following:

- Care for use as instructed and return equipment in good condition normal wear excepted, at the end of the rental period
- Pay for replacement cost of any rental equipment damaged, destroyed, or lost due to misuse, abuse or neglect
- Not modify any equipment without prior written consent of OTI
- Not allow the use of any equipment by anyone other than you the patient
- Notify OTI promptly if any equipment malfunctions and/or to allow an OTI representative to repair or provide replacement equipment within a time frame agreed upon
- Ultimately be responsible for your bill regardless of insurance coverage
- Make payment within 30 days of receipt of invoice
- Remember you are responsible for contacting us to arrange for prompt rental equipment pick-up. Thank you in advance for making arrangements promptly. To schedule a pick-up for your durable medical device call 1-877-255-0052. Our field personnel are available 24 hours a day, every day of the year.

INSURANCE AND BILLING INFORMATION

The OTI billing department is designed to bill your insurance company for the services you receive from us. If you have coverage from more than one health insurance company, please inform us as to which company is primary and should be billed first. Since each health insurance policy coverage varies, we suggest you call your insurance company if you have any questions regarding coverage. By filing an insurance claim for you, we hope to make the billing process trouble free. Regardless of insurance coverage, you are ultimately responsible for your bill. If your insurance carrier has questions or requests additional information from you, please respond promptly. If you have any questions regarding the status of your claim, we suggest you contact your insurance company directly. The billing department is ready to answer billing and insurance questions and can be reached at **1-888-351-4524 Monday-Friday, 8:30 am -4:30 p.m. (CST)**. Any other time you may leave a message and your call will be returned the next business day.

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).

The products and/or services provided to you by OTI are subject to the supplier standards contained in the Federal regulation shown at 42 Code of Federal Regulations Section 424.57(c). These standards concern business professional and operational matters (e.g., honoring warranties and hours of operation). The full text of these standards can be obtained from the U.S. Government Printing Office website: www.gpo.gov. Upon request we will furnish you a written copy of the standards.

NOTICE OF PRIVACY PRACTICES

Effective 4/14/03

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

OTI understands that your medical information is personal and we are committed to protecting this information. We create a record of the equipment, services, and financial information about you and we use this record to provide you with quality equipment and services, and to comply with certain legal requirements. This notice applies to all of our records pertaining to your care. This notice will tell you about the ways in which we may use and disclose your medical information. We also describe your rights and certain obligations we have regarding the use and disclosure of your medical information.

Privacy laws require that we ensure all of the following:

- We must maintain the privacy of your medical and financial information;
- We must provide you with this Notice, which explains our legal duties and privacy practices with respect to your protected health information; and,
- We must follow the terms of the notice that is currently in effect.

To see this document in it's entirety, visit www.orthotekinc.com or call 877-255-0052.