☐ NEW PATIENT ☐ CHANGE INFO

Althea's Footwear Solutions

PATIENT CONTACT INFORMATION

PLEASE PRINT LEGIBLY

LAST _____ FIRST _____ MI _____ _____
PATIENT NAME BIRTH DATE

_____
MAILING ADDRESS

_____ _____ _____ _____
CITY STATE ZIP CODE SOCIAL SECURITY NUMBER

H W _____ H W _____ _____
C PRIMARY PHONE NUMBER C SECONDARY PHONE NUMBER EMAIL ADDRESS

_____ _____
REFERRING PHYSICIAN (WHO THE PRESCRIPTION CAME FROM) PHONE

_____ _____
PRIMARY CARE PHYSICIAN (YOUR GENERAL DOCTOR) PHONE

_____
PRIMARY INSURANCE

_____
SECONDARY INSURANCE

ARE YOU AFFECTED BY DIABETES? ☐ NO ☐ YES
(if yes, please fill out Diabetes questionaire)

I understand that any insurance quoted by Althea's Footwear is not a guarantee of benefits. It is my obligation to know my insurance or to contact my insurance company for any questions.

Although we will bill your insurance company, the **FINAL BALANCE** is your responsibility and is due within 90 days from the time of delivery. If custom products are required we will ask for 50% down payment at time of order. **ALL CUSTOM ITEMS** as well as **COMPRESSION STOCKINGS ARE NON-REFUNDABLE.**

I herby authorize **ALTHEA'S FOOTWEAR SOLUTIONS INC.,** to bill my insurance carrier for services, which I have received, and assigned payment for those services to **ALTHEA'S FOOTWEAR SOLUTIONS, INC.,** to release information to my insurance company regarding my diagnosis and any services rendered.

_____ _____
SIGNATURE DATE

NAME _____ _____ _____
EMERGENCY CONTACT PHONE NUMBER RELATION

LABOR & INDUSTRY CLAIMS ONLY:

_____ _____
CLAIM # DATE OF INJURY

_____
EMPLOYER

_____ _____
CLAIMS ADJUSTER TELEPHONE NUMBER

Althea's Footwear Solutions
1932 Broadway
Everett, WA 98201
PH: 425-303-0108
FAX: 425-303-2539
www.Altheas.net

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Althea's Footwear Solutions
7501 Custer Road West
Lakewood, WA 98499
PH: 253-473-4311
FAX: 253-473-4408
www.Altheas.net

Office Policy

INSURANCE

Any insurance quoted is not a guarantee of benefits. It is the patient's obligation to know their insurance or to contact their insurance company for any questions. Insurance coverage for pedorthic devices and compression garments vary widely. We encourage you to contact your insurance carrier to determine what type of coverage is provided for your prescription. Keep in mind that your insurance policy may use certain fee schedules or allowances which may not coincide with our fees. *Therefore, you may be able to receive pedorthic products at little or no costs. Deductibles and co-pays may apply.* At Althea's Footwear Solutions, Inc., all amounts charged are usual and customary for the products and services we offer.

Althea's Footwear Solutions, Inc., accepts assignment only for Medicare, Medicaid, Worker's Compensation and other contracted insurance company claims. Any exceptions will require pre authorization from the third party to be billed. If you are unsure if we are contracted with your insurance company, please ask.

FEES AND PAYMENTS:
Our goal is to provide the best pedorthic care and services we can. We make every effort to keep our fees reasonable and to avoid unfairly passing on to all our patients the cost of unnecessary collection procedures. Therefore, all fees are due and payable at the time the services and/or devices are provided. In addition, payment is required on all special order, custom shoes, and foot orthotics. We accept Visa, Mastercard, Checks and Cash.

If it becomes apparent that a client does not intend to satisfy a financial obligation to Althea's Footwear Solutions, Inc., a collection agency or legal remedy may be employed to resolve the debt.

RETURNS:
All new unaltered shoes may be returned within seven days from the date of purchase for a refund or exchange. All returns must be in their *ORIGINAL* packaging.

Due to health regulations, compression garments are not returnable and may only be exchanged if we made a mistake on measuring.

ADJUSTMENTS:
There will be two adjustments at no charge within 60 days after purchase or shoes and orthotics. Beginning with the third adjustment or adjustments after 60 days there will be a $10.00 office fee per each 15 minute adjustment.

I have read (or has been read to me) the above information. I understand it to the best of my knowledge. I have asked questions that might be of concern to me.

Signature:_____ Date:_____

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PATIENT AGREEMENT

REQUEST FOR PROVISION OF SERVICE

I understand that by signing this agreement, I indicate my wish to purchase health care products or services or both from ALTHEA'S FOOTWEAR SOLUTIONS, INC.

INDICATIONS OF MEDICAL RESPONSIBILITY

I understand that I am under the supervision and control of my attending physician. I also understand that my physician has prescribed this treatment. I understand that the services at ALTHEA'S FOOTWEAR SOLUTIONS, INC., do not include diagnostic, prescriptive or other functions typically performed by licensed physicians, and that my physician is solely responsible for diagnosing and prescribing drugs and or therapy for my condition and otherwise supervising and controlling my medical care.

EXTENDED MEDICAL ASSIGNMENT

I certify that the information given by for payment under Medicare (title XVIII of the Social Security Act) or other medical insurance is correct.

1. The patient if physically and mentally competent must sign on his/her behalf. If they cannot sign for him/her self, a representative payee as designated by the Social Security Administration, or a legally appointed guardian may sign. The source of the signatory's authority should be state e.g. Social Security Appointed representative payee, court appointed guardian, etc.
2. This form is issued in lieu of the patient's signature on the "request for payment" form HCFA-1500 (i-84) and is, therefore an extension of that form. Anyone who misrepresents or falsifies essential information in making Medicare claims may, upon conviction, be subjected to fine and imprisonment under Federal Law. Furthermore, in signing the beneficiary authorizes any holder of medical or other information needed to process related Medical claims. He/she further permits a copy of the authorization to be used in place of the original.
3. On assigned claims, the provider agrees to accept the Medicare Carrier's allowable amount as the full charge for covered services the patient is responsible for the deductible, co-insurance, and non-covered services. This authorization may be canceled by mutual agreement of the provider and customer at any time by written notice to the Medicare Carrier.

I request payment under the Medical Insurance Part of Medicare be made directly to ALTHEA'S FOOTWEAR SOLUTIONS, INC., for services furnished to me during the effective period of the authorization. I have read and I agree to release information as specified in paragraph two above.

The undersigned certifies that he/she has read the foregoing and received copy, as well as a copy of the Bill of Rights and patient responsibilities documented on the attached form. The undersigned also certifies that he/she is the patient or is duly authorized by the patient as patient's general agent to execute the above and accept its terms.

This consent signed by _____ Dated _____
(Signature)

PATIENT NAME: _____
(Printed)

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PATIENT CONSENT FORM

Notice of Privacy Practice - HIPAA

Our Notice of Privacy Practice provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and healthcare operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Then patient understands that:

1. Protected health information may be disclosed or used for treatment, payment or health care operations.
2. The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
3. The Practice reserves this right to change the Notice of Privacy Policies.
4. The patient has the right to restrict the use of their information but the Practice does not have to agree to those restrictions.
5. The patient may revoke this consent in writing at any time and all future disclosures will then cease.
6. The Practice may condition treatment upon the execution of this consent.

This consent signed by _____ Date _____
(Signature)

In addition to my Doctor's offices and my Insurance companies, I give permission for Althea's Footwear to discuss my account with the following people:

Name:_____ Relation:_____

Name:_____ Relation:_____

Name:_____ Relation:_____

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PATIENT COPY

AFTER HOURS EMAIL CONTACT: althea@altheas.net

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DIABETES QUESTIONNAIRE

1.) Do you have Diabetes? ☐YES ☐NO (STOP, do not continue)

2.) How long ago did the doctor tell you that you have Diabetes?
☐Less than 1 year ☐1YR ☐2-4YRS ☐5YRS ☐6-9YRS ☐10+YEARS

3.) Are you insulin dependent? ☐YES ☐NO

4.) Are your daily sugar tests stable? ☐YES ☐NO

5.) What are your daily activities?_____
_____

6.) What are your occasional activities?_____
_____

7.) Do you have foot pain?
LEFT FOOT ☐YES ☐NO
RIGHT FOOT ☐YES ☐NO

8.) Do you **CURRENTLY** have?

	LEFT FOOT		RIGHT FOOT	
Callus	☐YES	☐NO	☐YES	☐NO
Ulcers	☐YES	☐NO	☐YES	☐NO
Toe Amputations	☐YES	☐NO	☐YES	☐NO

9.) Have you had **IN THE PAST**?

	LEFT FOOT		RIGHT FOOT	
Callus	☐YES	☐NO	☐YES	☐NO
Ulcers	☐YES	☐NO	☐YES	☐NO

10.) Do you or has the doctor told you that you have any decreased feeling in your feet?
☐YES ☐NO If so… how long?_____

11.) Do you or has the doctor told you that you have vascular problems?
☐YES ☐NO If so… how long?_____

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HIPAA NOTICE OF PRIVACY PRACTICES

Effective date: February 23rd 2017

We understand that health information about you and your health is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all the records of your care generated by this office, whether made by your personal doctor or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- Make sure that health information that identifies you is kept private.
- Give you this notice of our legal duties and privacy practices with respect to health information about you
- Follow the terms of the notice that is currently in effect.

How we may use and disclose health information about you:

- For treatment
- For health care operations
- For appointment reminders
- As required by law
- To avert a serious threat to health and safety
- As required by the Military, Veterans, or Worker's Compensation
- Public health risks
- Health oversight activities
- Lawsuits and disputes
- Law enforcement
- Coroners, health examiners and funeral directors
- National Security and Intelligence activities
- Protective Services for the President and others
- Security Officials for Inmates

Your rights regarding Health Information about you:

- Right to inspect and copy
- Right to amend
- Right to and accounting of disclosures
- Right to request restrictions
- Right to request confidential communications
- Right to a paper copy of this notice (full notice is available upon request)

Changes to this notice:
We reserve to the right to change this notice. We will post a copy of the current notice in our facility with the current effective date on the first page.

Complaints:
If you believe that your privacy rights have been violated, you may file a complaint with us. All complaints must be in writing. Please contact administrator at the location where you were treated to file a complaint.

Acknowledgement of Receipt of this Notice:
We will request that you sign a separate form acknowledging you have received a copy of this notice. This acknowledgement will become part of your records.

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MEDICARE 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).

As a patient receiving pedorthic services from **Althea's Footwear Solutions, Inc.** let it be known and understood you have the following rights:

1. A supplier must be in compliance with all applicable Federal and State licensure and regulatory requirements and cannot contract with an individual or entity to provide licensed services.
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 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. This standard requires that the location is 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. 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, 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 must agree not to initiate telephone contact with beneficiaries, with a few exceptions allowed. This standard prohibits suppliers from contacting a Medicare beneficiary based on a physician's oral order unless an exception applies.
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). *Implementation Date - October 1, 2009*
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. Must meet the surety bond requirements specified in 42 C.F.R. 424.57(c). *Implementation date- May 4, 2009*
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 C.F.R. 424.516(f).
29. DMEPOS suppliers are prohibited from sharing a practice location with certain other Medicare providers and suppliers.
30. DMEPOS suppliers must remain open to the public for a minimum of 30 hours per week with certain exceptions.

PATIENT COPY