KINETIC O&P LTD.

PATIENT INFORMATION

PATIENT INFORMATION	PATIENT NAME: _____ DOB: _____ ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____ CELL PHONE: _____ HOME PHONE: _____ EMERGENCY CONTACT NAME/PHONE: _____ EMAIL: _____ HEIGHT: _____ WEIGHT: _____ DIABETIC: YES or NO
PRIMARY INSURANCE	PRIMARY INSURANCE: _____ POLICY #: _____ GROUP #: _____ PHONE: _____
SECONDARY INSURANCE	SECONDARY INSURANCE: _____ POLICY #: _____ GROUP #: _____ PHONE: _____
PHYSICIAN INFORMATION	REFERRING PHYSICIAN: _____ PHONE: _____ PRIMARY PHYSICIAN: _____ PHONE: _____ DIABETIC PHYSICIAN: _____ PHONE: _____

MEDICAL HISTORY	**PLEASE CHECK ALL THAT APPLY** ____ Is your condition a result of an accident from employment? ____ Is your condition a result of an auto accident? ____ Is your condition a result of any other type of accident? If so, explain: _____ _____ General Health: ____ Poor ____ Fair ____ Good ____ Excellent Any health issues we should know about? _____ Reason for visit today? _____ Have you ever had the same or similar device? _____ If so, when? _____ From what company? _____ Activities/Hobbies: _____ _____

453 S. Main Street, Bourbonnais, IL 60914
PH: (815) 401-7260 FAX: (815) 401-7267

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MEDICAL HISTORY

Visit Date: _____

Patient Name _____ Patient DOB: _____

General Health ____ Excellent ____ Good ____ Fair

Tobacco Use ____ Yes ____ No

Falls in the last 6 months? ____ Yes ____ No

Hospital, ER, or Urgent Care Visits in the last 6 months? ____ Yes ____ No

Accident from Employment? ____ Yes ____ No Date _____ State _____
Description of Accident _____

Auto Accident? ____ Yes ____ No Date _____ State _____

Other Accident? _____

Condition Since Birth? ____ Yes ____ No

Have you received a same or similar device in the past 5 years? ____ Yes ____ No Date _____
Details, from what facility and when? _____

Do you have an amputation? ____ Yes ____ No

Patient currently has or has had: (check all that apply)

	Heart Problems		Hepatitis C		Alzheimer Disease
	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

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KINETIC O & P LTD: PATIENT COMPLIANCE DOCUMENTATION

HIPAA **RELEASE OF INFORNATION**	***Notice of Privacy Practices**: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, and the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you to read it carefully and completely before signing this Consent. ***Purpose of Consent**: By signing this form, you consent for Kinetic O & P LTD to use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. **This includes release of information** from your physicians, therapists, and others involved in the care and treatment.
COMMUNICATION AUTHORIZATION	I authorize Kinetic O & P LTD to leave messages on my cell phone / home phone/ and/or contact me by e-mail at _____
MEDICARE SUPPLIER STANDARDS	"The products and/or services provided to you by Kinetic O & P LTD are subject to the supplier standards contained in the Federal regulations shown at 42 Code of Federal Regulations Section 424.57©. 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 at http://ecfr.gpoaccess.gov. Upon request, we will furnish you a written copy of the standards"
WARRANTY POLICY	*The warranty period for custom orthoses and prostheses is three months for workmanship and materials. Needed adjustments or repairs within the warranty period, will be done at no charge. Within the warranty period, there will be a charge for adjustments or repairs that are a result of abuse, undue rough wear or physical changes of the wearer. If the device is altered by anyone other than Kinetic O & P LTD, the warranty does no apply. Componentry is warranted for a period of one year or for the period of time expressed by the manufacturer. An owner's manual with warranty information will provided to beneficiaries for all durable medical equipment where the manual is available. *Failure to contact Kinetic O & P LTD about fitting problems, or other concerns, or non-use of the device does not absolve the patient from responsibility of payment. Since the device is custom fabricated and prescribed by your physician, it cannot be returned for credit on the account. Prescribed "off-the-shelf" items cannot be returned for hygienic reasons. *It is in your best interest to communicate with your practitioner on a timely basis and allow us to resolve any problems you are experiencing as efficiently and quickly as possible. It is our goal to provide you with the best care possible, and we will make every effort to meet your needs. Please contact us if there is a question or concern that your practitioner cannot resolve.
COMPLAINT RESOLUTION	The patient has the right to freely voice grievances and recommend changes in care or services without fear of reprisal or unreasonable interruption of services. Service, equipment, and billing complaints will be communicated to the management. All complaints will be handled in a professional manner. All logged complaints will be investigated, acted upon, and responded to in writing or by telephone by a manager within a reasonable amount of time after the receipt of the complaint. If there is no satisfactory resolution of the complaint, the next level of management will be notified progressively and up to the president or owner of the company.
ASSIGNMENT OF BENEFITS	I authorize my insurance company to pay benefits directly to Kinetic O & P LTD. I understand my insurance company may not pay for services that are not a covered benefit or are not considered medically necessary. I also understand that there may be benefit limitations with no-fault carriers as deductibles and benefit maximums may apply. I agree to be financially responsible for all services provided by Kinetic O & P LTD.
SIGNATURE	**I HAVE READ, UNDERSTOOD, AND HEREBY AGREE TO ALL THE TERMS STATED ABOVE.** **X**_____ **X**_____ PATIENT OR AUTHORIZED REPRESENTATIVE SIGNATURE DATE **X**_____ PRINTED NAME OF PATIENT OR REPRESENTATIVE / RELATION TO PATIENT