SCOLIOSIS TECHNOLOGIES
The Measurable difference

P A T I E N T I N T A K E F O R M

Patient (legal) Name First: _____Last: _____

Parent or (guardian) Name First: _____Last:_____

DOB : _____ - _____ - _____ Age: _____ Email : _____

Phone/Home : _____ Cell: _____Work: _____

Street Address: _____

City, State, Zip: _____

I N S U R A N C E I N F O R M A T I O N

Responsible Party Name First: _____ Last: _____

Relationship to Patient: _____ Credit Card: _____ exp _____ ccv ____

Primary Insurance: _____ ID #: _____

Secondary Insurance: _____ ID #: _____

Social Security # _____ - _____ - _____ DOB : _____ - _____ - _____

Employer: _____ Group # _____

P H Y S I C I A N ' S I N F O R M A T I O N

Referring Physician's Name _____ Last: _____

Physician NPI #: _____ UPIN #: _____

Office Address : _____

Phone #: _____Fax: # _____Email : _____

I understand that by signing this agreement, I indicate my wish to purchase or obtain DME Products and/or services or both from the following _____or Integra Partners. I hereby authorize the following companies to request on my behalf and to collect directly all public and private insurance coverage benefits due for products and services arranged for patient by the following companies. In the event payments for Insurance benefits are made directly to the undersigned, the payee will endorse to _____all checks for such payments. In consideration of arranging to supply patient with any products and services ordered on behalf of patient the undersigned patient, spouse guarantor and/or guardian agree, that each of them is responsible for payment in the event insurance coverage rejects claim or reduces payment amount of claim. I have read and filled out this form accurately. I give permission for_____or it's affiliates to bill my insurance or my credit card. I also agree that if my insurance does not cover my product/service that I am responsible for full payment. **I** authorize _____ and the above companies to leave detailed phone messages for you, which may include private healthcare information. You also authorize _____ to utilize email as a form of communication with you.

→ _____ _____

Signature Date

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HIPAA Compliance Authorization Form

Company Notice of Privacy Practices

Effective Jan. 1st, 2021

HIPAA Privacy Authorization Form Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act - 45 CFR Parts 160 and 164)

We are required to keep your health information private, we are providing you with notice of our legal duties and practices with respect to the information we collect and maintain about you. To accommodate this requirement if a need to communicate health information should be required with persons other than the health care professionals or the insurance company, permission in writing will be requested. _____ will abide by the terms of this notice. We will not use or discuss your health information without your permission, except as described in this notice.

1. I hereby authorize all medical service sources and health care providers to use and/or disclose the protected health information (“PHI”) described below to my agent identified in my durable power of attorney for health care named _____
2. I authorize the release of my medical records as it pertains to my healthcare and receiving a product or billing a product for the above mentioned companies.
3. This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
4. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
5. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
6. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I _____, (parents name) acknowledge that I have received the above name companies privacy practices. I understand that a copy of this acknowledgement of receipt will be placed in my medical record and that I will be notified if the Privacy Practices of _____are at any time revised.

➔ _____ _____
Parent or legal guatdian Signature Date

_____ _____
Patient’s Printed Name Date

_____ _____
Witness Signature (If patient is unable to sign) Date

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ASSIGNMENT OF BENEFITS

☐ **CLINICAL PHOTOGRAPH RELEASE:** I understand that Scoliosis Technologies, or it's affiliates may obtain a photograph of me for clinical and/or advertising purposes. This photograph of me will remain in my records and may be forwarded to my treating medical professional(s) (physician, nurse, therapist,etc..) for clinical purposes. I also understand and waive all rights that I may have to any claims for payment or royalties in connection with any display televising or publication of the any pictures and further release Scoliosis Technologies, or its affiliates, it's directors, officers and staff from an liability in connection with the use of such pictures(s) and related materials.

Have you ever used a brace before for Scoliosis Treatment ? _____ If yes, please answer below

What type of Scoliosis brace did you receive? _____

When did you receive your most recent brace? (Month/Year) : _____ - _____

Has the child started Menses and if so When? _____

Who provided this device to you? (Orthotic/Prosthetic Facility) if applies:_____

What did you like about the device you received? if applicable:_____

What did you dislike about the device you received? if applicable: _____

Assignment of Benefits. As a courtesy to patients and their families Scoliosis Technologies and our affiliates submits claims to many third-party payors. I request that payment of authorized Medicaid or private benefits be made to the company above for any covered services furnished to me by to the company above. If my insurance carrier pays me directly, I agree to forward all funds to Scoliosis Technologies within ten (10) working days. Under some plans, including Medicaid. I understand some of the services I may receive may not be covered. I agree I am responsible for paying all non-covered amounts unless other wised provided by law, regulation or to the company above contractual relationships. I agree to be responsible for the full amount of the charges from the date of delivery if my third-party payor does not pay for the charges in a timely manner or my physician or I fail to provide within thirty (30) days the information necessary to submit the claim for payment.

Release of Records. I authorize Scoliosis Technologis or its affiliates or any IPA that the company is a member of to release to any governmental health care program and it's agents or to any private insurance company or its agents any information needed to determine my benefits or the benefits payable for The company above that is submitting the claim on my behalf.

Authorization to request medical records. I hereby authorize my attending physician to release all medical records pertaining to my Scoliosis Orthosis or Therapy treatment to Spinal Technologies or it's Associates.

I have read and received a copy of the **DMEPOS SUPPLIER STANDARDS**

Verification of information accuracy. I verify that to the best of my knowledge, the information I have provided in these two pages is accurate. I also agree to all the terms and agreements stated above, and on previous pages. I also agree and desire to use the device that is ordered by my physician.

Child's Name : _____

Patient/Guardian Signature: _____ Date: _____

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Financial Policy

If You Have...	You Are Responsible For...	Our Staff Will...
Insurance Plan with whom we have a contract (including VA)	If the services you receive are covered by the plan: patient portion (co-pays, deductibles, co-insurance, etc.) on or before date of delivery. If the services you receive are not covered by the plan: Payment in full on or before date of delivery.	Contact your insurance plan to obtain your eligibility, benefit information and patient portion (co-pays, deductibles, co-insurance, etc.) Submit your insurance claim.
Insurance Plan with whom we are Not Contracted or we are NOT an "in-network" provider.	Payment in full on or before date of delivery, unless your plan agrees to pay us directly.	Contact your insurance plan to obtain your eligibility and out-of-network benefit information. Submit your insurance claim if your plan agrees to pay us directly.
Medicare Part B	If you have Medicare Part B, and have not met your deductible, we ask that it be paid on or before date of delivery. If you do not have secondary insurance, Medicare co-insurance amount on or before date of delivery. If the total services are less than $250, full payment on or before date of delivery. Payment for any services not covered by Medicare on or before date of delivery.	Contact Medicare and secondary insurance plan (if applicable) to obtain your eligibility and benefit information Submit your insurance claim to Medicare, as well as any claims to your secondary insurance.
Medicaid	Depending on each state's Medicaid program, if the services you receive are covered by Medicaid: patient portion (if applicable) on or before date of delivery. Payment for any services not covered by Medicaid on or before date of delivery.	Contact local Medicaid office to obtain your eligibility, benefit information and patient portion (if applicable) as well as obtain prior authorization (if applicable).
Worker's Comp	If the services you receive are covered by the Worker's Comp: patient portion (if applicable) on or before date of delivery. Payment for any services not authorized by Worker's Comp on or before date of delivery.	Call your Worker's Comp plan to obtain your eligibility, benefit information and patient portion (if applicable) as well as obtain prior authorization (if applicable).
No Insurance	Payment in full due on or before date of delivery.	Advise you regarding charges for services provided.

How May I Pay? We accept payment by: cash, check, credit card or 3rd party patient financing. NOTE: Charges not covered by your insurance plan, as well as applicable co-payments and deductibles, are your responsibility. Returned check fee: $45.00 or state maximum, if less.

Regarding Insurance:
With proper insurance identification, this office will bill your insurance, managed care, HMO, or PPO provider. In the event we do not receive payment in full from your insurance provider within 45 days of billing, the amount owing will be billed to you and the payment is expected within 30 days after billing you, ALL CO-PAY AND DEDUCTIBLE PORTIONS ARE DUE PRIOR TO TREATMENT WHERE WE ARE A PARTICIPATING PROVIDER FOR SUCH PLANS.

Provider Changes:
It is the responsibility of the patient guarantor (s) to provide this office with any future changes in insurance plans, referrals and pre-certification forms (as required by your individual insurance plan) prior to treatment or continued monthly rental.

Regarding Automobile Accident, Worker Compensation and Third Party injury Cases:Please consult with our staff prior to treatment

Office Policy and Agreement:
Full payment is due at the time of service or within 30 days after billing in the event your insurance provider fails to make payment. We accept cash, check, and major credit cards. A charge of $25.00 will be added to your account for any check or payment instrument issued to this office, posted to your account and returned unpaid. In the event of non-payment of our charges, you agree to assume all cost of collections including attorney costs and statutory interest as allowed by law. This agreement is binding for patient initial list and all subsequent visits regardless of reason (including but not limited to monthly rental fees, office visits, consultations, and hospital visits/procedures provided by this practice and its staff)

Service Policy- Our services are provided by qualified licensed professional to meet your individual needs. Patient evolution consolation design, fitting and follow up adjustments for the Medicare mandated guidelines of ninety (90) days. These services may be necessary for reasons such as changes to your body volume, statues or functional capacity, wear and tear or damage. You will also be responsible for any charges that may be necessary to replace your device or component part. In these cases, we will honor any manufacturer warranty which may exist so that your responsibility may be limited to labor charges only.
If your insurance is provided by a managed care insurer (HMO, PPO etc) medicare or medicaid, you may need to obtain a referral or prescription from your primary care physician. Should your orthotic or prosthetic device require service and you are uncertain how to proceed: out staff will be pleased to assist you .

Custom made items and off the shelf items cannot be returned for a refund once it is fitted to you and you accept delivery. If a custom made item has been ordered and you change your mind after production has started you will be responsible for the fabrication charges they cannot be billed to your insurance company.

Again, Thank you for choosing us to service you, Please understand that payment of your bill is part of this treatment and care. This document does not cover all situations. As part of our commitment of service to you, we will make every attempt to verify your insurance benefits at the time your services are rendered. However, insurance verifications or authorization is not a guarantee of insurance payment. By signing below you agree you understand your financial obligation and agree to our terms.

➡ _____ _____

Patient or Guarantor **Date**