Arizona Prosthetic Orthotic Services

COMPANY RELATIONSHIP POLICY

WELCOME

We want you to know that we are dedicated to providing you with the best care possible. Our staff and technical personnel operate as a team and we take great pride in our training, knowledge and capabilities. The best care is based on a friendly and mutual understanding among staff, practitioner and patient. If any problems or questions arise, do not hesitate to bring them to our attention immediately. Thank you for choosing Arizona Prosthetic Orthotic Services for your orthotic and/or prosthetic needs.

Our Mission Statement

Arizona Prosthetic Orthotic Services

The purpose of Arizona Prosthetic Orthotic Services is to provide a state of the art facility for all patients, visitors and staff. Our facilities will strive for optimal results to rehabilitate each patient according to the physicians' orders. We will collaborate with the rehab team to provide professional input regarding our patients' Orthotic and Prosthetic management. Our staff will be trained to observe all safety regulations in order to provide a safe environment for all. Furthermore our facility will be committed to education for both the patient and practitioner to ensure better outcomes.

OFFICE HOURS AND TELEPHONE CALLS

Regular office hours are 8:00 a.m. to 5:00 p.m. Monday-Friday by appointment. For emergency and hospital calls we provide on-call service 24 hours a day, 7 days a week. We strongly believe in the value of your time and we will do our best to keep you from waiting. We appreciate 24 hour notice if you need to change your appointment. Our administrative staff tends to all incoming calls. This allows practitioners to attend to their scheduled patients with a minimum of interruptions. If you should find it necessary to contact a practitioner after hours, you can leave a message on the voice mail and your call will be returned promptly.

MEDICAL RECORDS RELEASE

I hereby authorize the release of any and all of my medical records to APOS that may be pertinent to the processing of my claims for payment.

FEES AND PAYMENT

We make every effort to keep the cost of your medical care reasonable. Payments for non-covered items must be paid up front before delivery of the product unless other financial arrangements have been made. For your convenience we accept MasterCard®, Visa®, Discover®, cash, and personal checks. Prescribed and custom-made appliances take time to properly manufacture. Therefore it may take additional visits in order to insure each appliance functions to its potential. To protect you and to comply with state law, **NO REFUNDS** will be permitted for prescribed or custom-made prosthetic /orthotic appliances.

INSURANCE POLICY

If you have health insurance, please note that this is an agreement between you and your carrier. We will submit your claim to insurance, based upon the type of coverage you have, for reimbursement. Ultimately you are responsible for the services provided and the fees incurred. It is our policy to charge our patient and their insurance in a fair and consistent manner. Our fees are set at usual and customary rates for this purpose.

PATIENT RIGHTS

I have received a copy of my patient's rights and agree with the company's policy.

_____ _____

Signature **Date**

Acknowledgement of Receipt of Notice of Privacy Practices

I certify that I have received a copy of Arizona Prosthetic Orthotic Service's (APOS) Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of APOS's health care operations. The Notice of Privacy Practices also describes my rights and APOS's duties with respect to my protected health information.

The Notice of Privacy Practices is posted in the waiting room area and on APOS's website at www.apos.net .

_____

Signature of Patient or Personal Representative

_____

Printed Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

_____

Date

Dear Valued Patient,

Our office policy is to verify your coverage and eligibility benefits prior to service being provided to you. ***Please note, verification of benefits and obtaining prior authorization is not a guarantee of payment.*** Benefits are determined once your insurance company receives the claim (bill) for the services provided to you.

Although our office staff is trained to ask all appropriate questions such as exclusions/limitations on your plan, **we cannot guarantee that services will be covered** and ultimately it is your insurance company that determines what benefits are eligible for payment.

Please be advised that you are financially responsible for all co-payments, deductibles, etc. as well as any and all non-covered services and fees of 35% or more if your account is forwarded to a collections agency.

All deductibles and co-insurance payments are due at the time of service.

Thank you for choosing APOS for all your orthotic/prosthetic needs.

_____

Signature of Patient or Personal Representative

_____

Printed Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

_____

Date

Patient Registration Form

Patient Name: _____ **Date of Birth:** _____

SSN: _____ **Sex:** _____ **Marital Status:** Single Married Other:_____

Primary Phone: ( ) _____ Cell Home Work **Alt. Number:** ( ) _____ Cell Home Work

E-mail Address: _____

****For Minors Only****

Parent/Guardian Contact: _____

****Primary Address****	****Alternative Address****
Street:	**Street:**
City:	**City:**
State & Zip:	**State & Zip:**

******This information must be given and fully completed in order for APOS to process your claim******

Height: _____ **Weight:** _____ **Shoe Size:** _____

Referring Doctor: _____ **Are you a diabetic?** **YES** **NO**

~If you ARE a diabetic, who is your treating physician/ primary care physician?~

Name: _____ **Phone:** _____

Is this a work related injury?: **YES** **NO** ***If so, please provide the following Worker Comp info:***

Company Name: _____

Claim Number: _____ Date of injury: _____

Adjuster: _____ Phone: _____

Employer: _____ **Phone:** _____

Address: _____

Primary Insurance: _____ Phone #: _____

Subscriber's Name: _____ Subscriber's Date of Birth: _____

Relation: _____ ID# _____ Group# _____

Secondary Insurance: _____ Phone #: _____

Subscriber's Name: _____ Subscriber's Date of Birth: _____

Relation: _____ ID# _____ Group# _____

The information provided above is full and accurate to my knowledge. If my insurance company fails to pay for services rendered within 90 days, I agree to be responsible for all charges of services rendered and interest accrual of 1.5% per month. I also understand that the interest rate of 1.5% will be added to the balance of my account on a monthly basis 90 days after services are rendered. I further release any medical information to process this claim and authorize payment of benefits to the provider for services rendered. I may also be charged any additional fees (35% or more) that may be added to my account if my account is turned over to a collection agency for failure to pay. I agree to pay all fees, if any, in the case of a cancelled or returned check submitted by myself to APOS. I have reviewed this information and verify that it is correct. I know that I am responsible for any financial loss, due to inaccurate information provided by me.

****Patient** Signature:** _____ **Date:** _____