REAL LIFE PROSTHETICS™

Patient History Form

To be completed by Patient/Responsible Party

Patient Name: _____ **Date:** _____

Date of Birth: _____ **Height:** _____ **Weight:** _____ **Shoe Size:** _____

Assisted Device: (*check all that apply*)

- ☐ Crutches
- ☐ Cane
- ☐ Walker
- ☐ Wheelchair
- ☐ Motorized Wheelchair or Scooter

Employment:

- ☐ Employed
  Job Title: _____
- ☐ Disability
- ☐ Unemployed/Previously Employed
  Job Title: _____

Home Set-up: _____ *Story Home* _____ *Stairs to Enter Home* _____ *Stairs to Bedroom*

Do you use Tobacco? ☐ Yes ☐ No

Rehabilitation Training PT/OT? ☐ Yes ☐ No

If "YES" Where: _____

PT/OT Name: _____

Phone Number: _____

Medical History:

- ☐ Diabetes
- ☐ Stroke (CVA)
- ☐ Peripheral Vascular Disease
- ☐ Visual Impairment
- ☐ Cardiovascular Disease
- ☐ Other
- ☐ Urinary Incontinence
- ☐ Depression
- ☐ Arthritis/Osteoarthritis
- ☐ MRSA
- ☐ Kidney Disease
- ☐ High Blood Pressure
- ☐ Hearing Loss
- ☐ Allergies *(list below)*

_____

_____

Any other medical condition you may think would make orthotic/prosthetic fit or function more complex, please specify:

_____

_____

_____

Past Surgical History: *(date and procedure)*

_____

_____

_____

Activities Prior to Injury/Amputation:

_____

_____

_____

Short Term/Long Term Goals:

_____

_____

_____

_____ _____

Patient/Responsible Party Signature *Date*

RLP PATIENT ACCOUNT #: _____

PATIENT INFORMATION

Last, First Name: _____ **MI:** ____ **Gender:** _____ **Marital Status:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone #: _____ **Work Phone #:** _____ **Cell Phone #:** _____

SSN: _____ **Date of Birth:** _____ **eMail Address:** _____

RESPONSIBLE PARTY *(if different from patient)*

Last, First Name: _____ MI: ____ Gender: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Work Phone #: _____ Relationship to Patient: ☐ Spouse ☐ Parent ☐ Other *please specify* _____

SSN: _____ Date of Birth: _____

INSURANCE INFORMATION

Primary Insurance: _____ Secondary Insurance: _____

Address: _____ Address: _____

Phone #: _____ Phone #: _____

Policy #: _____ Policy #: _____

Group #: _____ Group #: _____

Subscriber Name: _____ Subscriber Name: _____

3rd Insurance: (*if applicable*) _____

REFERRAL INFORMATION

Prescribing MD: _____ Phone #: _____

Primary Care Physician: _____ Phone #: _____

Physical Therapist: _____ Phone #: _____

How did you hear about Real Life Prosthetics™? _____

WORKERS' COMP INFORMATION

Insurance Carrier: _____ Employer: _____

Address: _____ Phone #: _____

City: _____ State: _____ Zip Code: _____

Date of Injury: _____ Case/Claim #: _____ Adjuster: _____

EMERGENCY CONTACT

Name: _____ Phone #: _____

Relationship: _____

I acknowledge that the above information is correct. I will immediately notify Real Life Prosthetics™ of any changes. I understand that if I fail to call Real Life Prosthetics™ office to cancel a scheduled appointment 24-hours in advance or I do not show up for that appointment, I may be charged a $30.00 No-Show fee.

_____ _____

Patient/Responsible Party Signature *Date*

PATIENT AGREEMENT / AOB / XB

Account Number: _____

Patient Name: _____ Date of Birth: _____

REQUEST FOR PROVISION OF SERVICES

I understand that by signing this agreement, I indicate my wish to purchase health care products or services or both from Maryland Real Life Designs, LLC (MRLD).

INDICATION 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 the therapy noted as part of my treatment. I understand that the services of MRLD 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. I agree to notify MRLD of any changes insurance coverage or status.

AGREEMENT TO PAY

In consideration of MRLD undertaking to supply patient with any products and services ordered by patient or behalf of patient. The undersigned patient, spouse, guarantor and/or guardian agree that each of them is responsible for payment to MRLD for all such products and services provided patient. In addition, I agree to pay the balance due in full upon receipt of an invoice, unless prior written arrangements have been made. If payment is not made, I/we understand that MRLD will follow its normal collection policy. I also agree to pay all collection fees, attorney fees, and court costs if MRLD has followed through with any collection procedures.

RELEASE OF INFORMATION

To undersigned authorize our insurer(s) and any third-party payer who provides patient with coverage to disclose to MRLD any information regarding such coverage, including but not limited to A) payments made by such insurer(s) or third-party payers(s) to any of us; B) the scope and extent of coverage available from time to time, and allow MRLD to release patient information. Patient authorizes all medical personnel to provide information to MRLD concerning his/her medical history, as it may relate to patient's home therapy.

CREDIT CHECK AUTHORIZATION AND CREDIT TERMS

MRLD is authorized to verify any information I have disclosed and perform a credit investigation for the purpose of extending credit for the purchase of orthotic/prosthetic supplies. In addition, they may answer any questions from creditors about my credit and account experiencing with MRLD.

ASSIGNMENT OF BENEFITS

The undersigned hereby authorize MRLD to request on my behalf and to collect directly all public and private insurance coverage benefits due to products and services supplied patient by MRLD. In the event that payments for insurance benefits are made directly to any of the undersigned, the payee will endorse to MRLD all checks for such payments. Responsibility for overpayments accepted per statement.

HICN _____

EXTENDED MEDICARE ASSIGNMENT

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

1. The patient, if physically and mentally competent, must sign on his/her behalf. If cannot sign for himself/herself, a representative payee as designed by the Social Security Administration, or a legally appointed guardian may sign: the source of the signatory's authority should be stated. (*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 HCFA-1500 (1-84) 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 about himself/herself to release to Social Security Administration or its intermediaries or carrier any information needed to process related Medicare claims. He/She further permits a copy of the authorization to be used in place of this original.
3. On assigned claims, the provider agrees to accept the Medicare Carriers allowable amount as the full charge for coverage services; the patient is responsible for the deductible, co-insurance, and non-covered services. This authorization may be cancelled by mutual agreement of the provider and customer at any time by written notice to the Medicare Carrier.

I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished me by or in MRLD, including physician services. I authorize any holder of medical or other information about me to release to the Center of Medicare and Medicaid Services and its agents any information needed to determine these benefits for related services.

For Medicare Patients Only ☐ **I certify that I have received a copy of the Medicare Suppliers Standards**

The undersigned certifies that he/she has read the foregoing and certifies that he/she is the patient or is duly authorized by the patient as patient's general agent to execute the above and accepted its terms.

Note: A duplicate copy of this Agreement and Consent shall be considered the same as an original.

_____

Patient/Spouse/Guarantor/Guardian/Signature **Relationship to Patient** **Date**

MARYLAND REAL LIFE DESIGNS, LLC
dba REAL LIFE PROSTHETICS™
Acknowledgement of Receipt Form

I certify that I have received a copy of the following Real Life Prosthetics (RLP) forms/information:

Check all that apply:

- ☐ Notice of Privacy Practices **ALL "New" RLP Patients**
- ☐ Patient Email and Text Message Informed Consent **ALL "New" RLP Patients**
- ☐ Financial Policy and Procedures **ALL "New" RLP Patients**
- ☐ Appointment and Funding Procedures After Initial Consult and/or Evaluation **ALL "New" RLP Patients**
- ☐ Medicare DMEPOS Supplier Standards **ALL "New" MEDICARE RLP Patients ONLY**

The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information (*also known as PHI*) that might occur in my treatment, payment of my bills or in the performance of RLP's health care operations. The Notice of Privacy Practices also describes my rights and RLP's duties with respect to my protected health information. The Notice of Privacy Practices is posted in RLP's office and on the website at **www.RealLifeProsthetics.com**

RLP reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent to me in the mail, asking for one at the time of my next appointment, or accessing RLP's website at *www.RealLifeProsthetics.com*

I give consent to RLP to use my PHI in order to proceed with my recommended treatment.

I understand the risks associated with the use of email and text messaging as a form of communication between Real Life Prosthetics and me, and consent to the conditions and instruction outlined in the Patient Email and Text Message Informed Consent, as well as any other instructions Real Life Prosthetics may impose to communicate with me by email or text message.

_____ _____

Email Address *Cell Phone Number*

The Financial Policy and Procedures describes what I may expect regarding the billing and payment for all billable devices/services that RLP provides to me. The Financial Policy and Procedures are also posted in RLP's office.

The Appointment and Funding Procedures After Initial Consult and/or Evaluation explains what to expect regarding time frames it may take to deliver your device to you.

The Medicare DMEPOS Supplier Standards describes what RLP must comply with in order to continue servicing Medicare Patients and billing Medicare for devices/services. The Medicare Standards are also posted in RLP's office.

_____ _____

Signature of Patient or Personal Representative *Date*

_____

Printed Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

REAL LIFE PROSTHETICS™
Notice of Privacy Practices

This *Notice of Privacy Practices* describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

If you have any questions about this *Notice of Privacy Practices*, contact our Privacy Officer Sandra Yeater at (410) 569-0606 or email at *sandy@reallifeprosthetics.com*

Get an Electronic or Paper Copy of Your Medical Record:
You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30-days of your request. We may charge a reasonable, cost-based fee.

OUR COMMITMENT TO PROTECT YOUR HEALTH INFORMATION
This *Notice of Privacy Practices* describes how we may use and disclose your protected health information (*also known as PHI*) to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Your "protected health information" means any of your written and oral health information, including your demographic data that can be used to identify you. This is health information that is created or received by your health care provider, and that relates to your past, present or future physical or mental health or condition. We are strongly committed to protecting your medical information. We create a medical record about your care because we need the record to provide you with appropriate treatment and to comply with various legal requirements. We transmit some medical information about your care in order to obtain payment for the services you receive, and we use certain information in our day-to-day operations. This *Notice of Privacy Practices* will let you know about the various ways we use and disclose your medical information, describe your rights and our obligations with respect to the use or disclosure of your medical information. We will also ask that you acknowledge receipt of this *Notice of Privacy Practices* the first time you come to or use any of our facilities, because the law requires us to make a good faith effort to obtain your acknowledgment.

We are required by law to (1) make sure that any medical or health information that we have that identifies you is kept private, and will be used or disclosed only in accord with this *Notice of Privacy Practices* and applicable law; (2) give you this Notice of our legal duties and our privacy practices; and (3) abide by the terms of the *Notice of Privacy Practices* that is in effect from time to time.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

A. <u>Uses and Disclosures of Protected Health Information for Treatment, Payment and Healthcare Operations</u>

Your protected health information may be used and disclosed by your Orthotist or Prosthetist, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of this facility. Following are examples of the types of uses and disclosures of your protected health care information that this facility is permitted to make. We have provided some examples of the types of each use or disclosure we may make, but not every use or disclosure in any of the following categories will be listed.

For Treatment:
We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related treatment. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. *For example, we would disclose your protected health information, as necessary, to the physician that referred you to us*. We will also disclose protected health information to other health care providers who may be treating you when we have the necessary permission from you to disclose your protected health information.

For Payment:
Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services, we recommend for you such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. We may also tell your health plan about an orthotic or prosthetic device you are going to receive to obtain prior approval or to determine whether your plan will cover the device.

For Healthcare Operations:
We may use or disclose, as needed, your protected health information in order to support the business activities of this facility. These activities include, but are not limited to, quality assessment activities, employee review activities, legal services, licensing, and conducting or arranging for other business activities. We may share your protected health information with third party "business associates" that perform various activities (*e.g., billing, transcription services*) for this facility. Whenever an arrangement between our facility and our business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

Treatment Alternatives:
We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Appointment Reminders:
We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

Sign In Sheets:
We may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your Orthotist or Prosthetist is ready to see you.

Marketing and Health Related Benefits and Services:
We may also use and disclose your protected health information for other marketing activities. *For example, we may send you information about products or services that we believe may be beneficial to you*. You may contact our Privacy Contact to request that these materials not be sent to you.

Sale of the Practice:
If we decide to sell this practice or merge or combine with another practice, we may share your protected health information with the new owners.

B. Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke your authorization, at any time, in writing. You understand that we cannot take back any use or disclosure we may have made under the authorization before we received your written revocation, and that we are required to maintain a record of the medical care that has been provided to you. The authorization is a separate document, and you will have the opportunity to review any authorization before you sign it. We will not condition your treatment in any way on whether or not you sign any authorization.

C. Other Permitted and Required Uses and Disclosures That May be Made Either with Your Agreement or the Opportunity to Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your Orthotist or Prosthetist may, using their professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare:

Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, orally or in writing, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose your protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location or general condition.

D. Other Permitted and Required Uses and Disclosures That May be Made Without Your Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to object.

Required By Law:

We may use or disclose your protected health information to the extent that the use or disclosure is required by federal, state, or local law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health:

We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury, or disability. A disclosure under this exception would only be made to somebody in a position to help prevent the threat to public health.

Communicable Diseases:

We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight:
We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect:
We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. We will only make this disclosure if you agree or when required or authorized by law. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Military and Veterans:
If you are a member of the military, we may release protected health information about you as required by military command authorities.

Food and Drug Administration:
We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings:
We may disclose your protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal *(to the extent such disclosure is expressly authorized*), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement:
We may also disclose your protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes might include: (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (*not on the facility's premises*) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation:
We may disclose your protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye, or tissue donation purposes.

Research:
Under certain circumstances, we may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity:
Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security:
When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the U.S. Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation:
We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally established programs that provide benefits for work-related illnesses and injuries.

Inmates:
We may use or disclose your protected health information if you are an inmate of a correctional facility and your Orthotist or Prosthetist created or received your protected health information in the course of providing care to you.

Required Uses and Disclosures:
Under the law, we must make disclosures to you and when required by the Secretary of the U.S. Department of Health and Human Services to investigate or determine our compliance with the requirements of the final rule on Standards for Privacy of Individually Identifiable Health Information.

2. YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of your protected health information contained in your medical and billing records and any other records that your Orthotist or Prosthetist uses for making decisions about you, for as long as we maintain the protected health information.

To inspect and copy your medical information, you must submit a written request to the Privacy Contact listed on the first and last pages of this *Notice of Privacy Practices*. If you request a copy of your information, we may charge you a fee for the costs of copying, mailing or other costs incurred by us in complying with your request.

We may deny your request in limited situations specified in the law. *For example, you may not inspect or copy psychotherapy notes; or information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and certain other specified protected health information defined by law*. In some circumstances, you may have a right to have this decision reviewed. The person conducting the review will not be the person who initially denied your request. We will comply with the decision in any review. Please contact our Privacy Contact if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this *Notice of Privacy Practices*. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your Orthotist or Prosthetist is not required to agree to a restriction that you may request. If the Orthotist or Prosthetist believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your Orthotist or Prosthetist does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your Orthotist or Prosthetist. You may request a restriction by submitting a request in writing or contacting Privacy Contact person.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Contact.

You may have the right to have your Orthotist or Prosthetist amend your protected health information. This means you may request an amendment of your protected health information contained in your medical and billing records and any other records that your Orthotist or Prosthetist uses for making decisions about you, for as long as we maintain the protected health information. You must make your request for amendment in writing to our Privacy Contact and provide the reason or reasons that support your request.

We may deny any request that is not in writing or does not state a reason supporting the request. We may deny your request for an amendment of any information that (1) was not created by us, unless the person that created the information is no longer available to amend the information; (2) is not part of the protected health information kept by or for us; (3) is not part of the information you would be permitted to inspect or copy; or (4) is accurate and complete.

If we deny your request for amendment, we will do so in writing and explain the basis for the denial. You have the right to file a written statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Contact to determine if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right only applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this *Notice of Privacy Practices*. It also excludes disclosures we may have made to you, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions, and limitations. You must submit a written request for disclosures in writing to the Privacy Contact. You must specify a time period, which may not be longer than 6-years and cannot include any date before April 14, 2003. You may request a shorter timeframe. Your request should indicate the form in which you want the list (*e.g., on paper, etc.*). You have the right to one free request within any 12-month period, but we may charge you for any additional requests in the same 12-month period. We will notify you about the charges you will be required to pay, and you are free to withdraw or modify your request in writing before any charges are incurred.

You have the right to obtain a paper copy of this notice from us, upon request to our Privacy Contact, or in person at our office, at any time, even if you have agreed to accept this notice electronically.

3. COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you in any way for filing a complaint, either with us or with the Secretary.

You may contact our Privacy Officer at (410) 569-0606 for further information about the complaint process.

4. CHANGES TO THIS NOTICE

We reserve the right to change the privacy practices that are described in this *Notice of Privacy Practices*. We also reserve the right to apply these changes retroactively to protected health information received before the change in privacy practices. You may obtain a revised *Notice of Privacy Practices* by calling the office and requesting a revised copy be sent in the mail, asking for one at the time of your next appointment, or accessing our website at *www.RealLifeProsthetics.com*

This notice was published and becomes effective on April 14, 2003.

Patient Email and Text Message Informed Consent

You may give permission to Real Life Prosthetics to communicate with you by email and text message. This document provides information about the risks of the forms of communication, guidelines for email and text communication, and how we use email and text communication. The *Acknowledgement of Receipt Form* will be used to document your consent for communication with you by email and text message.

1. HOW WE WILL USE EMAIL AND TEXT MESSAGING

We use these methods to communicate only non-sensitive and non-urgent issues. All communications to or from you may be made a part of your medical record. You have the same right of access to such communications as you do the remainder of your medical record. We will not disclose your emails or text messages to researchers or others unless allowed by state or federal law. Please refer to our *Notice of Privacy Practices* (*pages 1 through 7 of this document*) for information as to permitted users of your health information and your rights regarding privacy matters.

2. RISK OF USING EMAIL AND TEXT MESSAGES

The use of email and text messages has a number of risks that you should consider. These risks include, but are not limited to the following:

a) Emails and texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
b) Senders can easily misaddress an email or text and send the information to an undesired recipient.
c) Backup copies of emails and texts may exist even after the sender and/or recipient has deleted his or her copy.
d) Employers and online services have a right to inspect emails and texts sent through their company systems.
e) Emails and texts can be intercepted, altered, forwarded, or used without authorization or detection.
f) Emails and texts can be used as evidence in court.
g) Email and text messaging may not be secure, and therefore it is possible that a third party may breach the confidentiality of such communications.

3. CONDITIONS OF THE USE OF EMAIL AND TEXT MESSAGE

Real Life Prosthetics cannot guarantee but will use reasonable means to maintain security and confidentiality of email and text information sent and received. You must acknowledge and consent to the following conditions:

a) **IN A MEDICAL EMERGENCY, DO NOT USE EMAIL, CALL 911**. Do not email for urgent problems. If you have an urgent problem during regular business hours, please call (410) 569-0606. Urgent messages or needs should be relayed to us by using regular telephone communication and may include text messages.
b) Emails should not be time sensitive. While we try to respond to email messages daily, we cannot guarantee that any particular email will be read and responded to within any particular period of time. If you have not heard back from us within three days, call our office to follow-up if we have received your email.
c) You should speak to our office directly to discuss complex and/or sensitive situations rather than send email or text messages regarding such situations.
d) Email and text messages may be filed electronically into your medical record.
e) Clinical staff will not forward your identifiable email and texts to outside parties without your written consent, except as authorized by law.
f) You should use your best judgement when considering the use of email or text messages for communication of sensitive medical information. Clinical staff are not responsible for the content of messages.
g) Real Life Prosthetics is not liable for breaches of confidentiality caused by you or any third party.
h) It is your responsibility to follow up with Real Life Prosthetics if warranted.

4. WITHDRAWAL OF CONSENT

I understand that I may revoke this consent at any time by so advising Real Life Prosthetics in writing. My revocation of consent will not affect my ability to obtain future health care, nor will it cause the loss of any benefits to which I am entitled.

5. PATIENT ACKNOWLEDGEMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the use of email and text messaging as a form of communication between Real Life Prosthetics and me, and consent to the conditions and instruction outlined, as well as any other instructions Real Life Prosthetics may impose to communicate with me by email or text message.

REAL LIFE PROSTHETICS™
Financial Policy and Procedures

FOR PATIENTS WITH INSURANCE

If you have covered benefits for Orthotic and Prosthetic (O&P) devices/services and Real Life Prosthetics (RLP) is a participant of your insurance company, we will be happy to submit a claim for you. Your insurance company will be billed at the time of delivery. Be advised that RLP will contact your insurance company (*when appropriate*) to verify eligibility and benefits for the devices(s)/service(s) you require from us prior to proceeding with fabrication and delivery. If you have a deductible and/or co-pay, you will be responsible for a 50% deposit in order to proceed and the balance will be due at delivery. We accept cash, checks, Care Credit, American Express, MasterCard, and Visa.

Please realize that our professional services are provided to a person, not to an insurance company. The insurance company is responsible to the patient, and the patient is responsible to RLP. We cannot assume that an insurance company will pay all charges. However, we will make every effort to get your claim paid by filing it with all required documentation in a timely manner.

SELF PAY *(not including workers compensation, charity…)*

If you have NO insurance coverage for our services and must pay out-of-pocket, we require a 50% deposit to proceed and the remaining balance due at delivery. Depending on the cost of the devices(s)/service(s), we may arrange a payment plan that will fit your needs and ours.

If you have questions, we will be happy to discuss them with you. We value all our patients and will continue to provide you with our best professional care.

Real Life Prosthetics Staff

FOR ADDITIONAL INFORMATION, REFER TO THE "APPOINTMENT AND FUNDING PROCEDURES."

May 3, 2003
Updated February 8, 2006
Updated January 15, 2007
Updated February 2, 2011
Updated 2013
Updated 2023

REAL LIFE PROSTHETICS™
Appointment and Funding Procedures After Initial Consult and/or Evaluation

For those who plan for Real Life Prosthetics to bill your insurance company.

After your initial face-to-face consult and/or evaluation for Orthotic and/or Prosthetic devices with Real Life Prosthetics (RLP), the following **MUST** occur if you want your insurance company billed for your device/service:

- Your practitioner completes and passes his/her clinic note to the Funding/Administrative Department. **This can take between 1 and 2 business days after consult and/or evaluation**.
- Coding is generated, diagnosis(*es*) are added, and your insurance is contacted to verify eligibility, to check benefits for your device, and verify prior authorization requirements. If we find that you have no benefit for the device/service you are needing or that there will be a cost to you (*i.e., copay, deductible, etc.*), we will call you to verbally quote and let you know when we expect your payment… this will allow you to make a decision as to whether or not you want to proceed.

  If verbal approval is given to RLP for any patient payment due, a suggested Standard Work Order (SWO) is typed to include **insurance required** details and is faxed to your physician for review and signature if acceptable.

  If we find we are still needing a prescription and face-to-face clinic notes from your physician (*required by Medicare, managed Medicare and various other insurances*) we will contact your physician and request these documents as well.

  If prior authorization is required, all documentation is forwarded to your insurance as needed. **These processes can take between 2 days and 2+ weeks**. It all depends on how quickly we received all required documentation from your physician and prior authorization from your insurance company if needed. RLP follows up with your physician and insurance if the documentation and/or prior authorization is not received in a timely manner.

  NOTE: RLP cannot move forward with ordering/fabrication of our device until we have ALL documentation, as well as prior authorization if it's required. As soon as we do have everything we need, based on your insurance policy and requirements, RLP's Technical lab is notified to begin the ordering/fabrication process.
- **For Custom Orthotic Devices (FO, KAFO, KO…)** the ordering/fabrication process and completing a quality control device check can take between 2 and 4 weeks to finish and be ready for delivery to you.
- **For Most Custom Prosthetic Devices (Artificial Limbs)** this process **takes between 4 and 8 weeks** due to requiring you to have multiple appointments during the process (*i.e., test sockets, fitting, etc.*) leading up to the final fit and delivery.

PLEASE KEEP IN MIND – RLP works hard for our patients, and we know and understand you want/need your device "yesterday." With this being said, we move as quickly as possible to complete our processes so you can be provided with what you need ASAP. It's important to us that we do everything necessary to get your claim paid so there's no unexpected costs for you.

It's possible for you to receive your device sooner than what's outlined above. **HOWEVER**, due to circumstances outside of our (RLP) control – backordered parts, shipping delays, patient availability to schedule, and response time from your physician and your insurance, it may take some time before your device is delivered to you.

If you have questions, please call our office at (410) 569-0606 and you will be directed to the appropriate department/person based on your question/concern. We value all our patients and will continue to provide you with our best professional care.

Real Life Prosthetics Staff

Updated 2023

MEDICARE DMEPOS SUPPLIER STANDARDS

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 supplier standards, in their entirety, are listed in 42 CFR § 424.57(c).

1. A supplier must be in compliance with all applicable Federal and State licensure and regulatory requirements.
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. A supplier must have an authorized individual (*whose signature is binding*) sign the enrollment application for billing privileges.
4. A supplier must fill orders from its own inventory, or contract with other companies for the purchase of items necessary to fill orders. A supplier may not contract with any entity that is currently excluded from the Medicare program, any State health care programs, or 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 and must maintain a visible sign with posted hours of operation. The location must be 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 Centers for Medicare & Medicaid Services (CMS) or its agents to conduct on-site inspections to ascertain the supplier's compliance with these standards.
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 is prohibited from direct solicitation to Medicare beneficiaries. For complete details on this prohibition see 42 CFR § 424.57(c)(11).
12. A supplier is responsible for delivery of and must instruct beneficiaries on the use of Medicare-covered items and maintain proof of delivery and beneficiary instruction.
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 cost either directly, or through a service contract with another company, any 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*) for beneficiaries.
16. A supplier must disclose these standards to each beneficiary it supplies a Medicare-covered item.
17. A supplier must disclose 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 complains 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 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 specified products and services, for which the supplier is accredited in order for the supplier to receive payment for those specific products and services (*except for certain exempt pharmaceuticals*).
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. A supplier must meet the surety bond requirements specified in 42 CFR § 424.57(d).
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 CFR § 424.516(f).
29. A supplier is prohibited from sharing a practice location with other Medicare providers and suppliers.
30. A supplier must remain open to the public for a minimum of 30-hours per week except physicians (*as defined in section 1841(j)(3) of the Act*) or physical and occupational therapists or a DMEPOS supplier working with custom made orthotics and prosthetics.

DMEPOS suppliers have the option to disclose the following statement to satisfy the requirement outlined in Supplier Standard 16 in lieu of providing a copy of the standards to the beneficiary.

> The products and/or services provided to you by (*supplier legal business name or DBA*) are subject to the supplier standards contained in the Federal regulations shown at 42 Code of Federal Regulations Section 424.57(c). These supplier 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 *https://www.ecfr.gov* Upon request we will furnish you a written copy of the standards.