MEDICAL ART RESOURCES, INC.
3400 S. 103rd Street, Suite 200 Greenfield, WI 53227
telephone 414-543-1002 facsimile 414-543-0137

PATIENT REGISTRATION INFORMATION

Personal Information

Patient's Name: | Birth Date: | Home Phone:

Address: | Work Phone: | Cell Phone:

City State Zip: | Email:

Parent/Guardian Name (for minor patient): | Work Phone: | Cell Phone:

Emergency Contact: | Phone:

Medical Information

Type of prosthesis needed:

Cause: ☐ Congenital (birth difference) ☐ Traumatic injury ☐ Disease and/or Surgery

Diagnosis: | Date of traumatic injury or surgery:

Referring Physician Name: | Phone:

Address: | City State Zip:

Please check yes (Y) or no (N)

Y	N	RELEVANT CONDITIONS	Y	N	RELEVANT HISTORY	
☐	☐	Diabetes or circulatory problems	☐	☐	Keloid formation	
☐	☐	Eczema/Psoriasis	☐	☐	Allergies: _____	
☐	☐	Arthritis	☐	☐	Pacemaker	**DATE COMPLETED**
☐	☐	HIV + AIDS	☐	☐	Radiation therapy	_____
☐	☐	MRSA, Hepatitis	☐	☐	Chemotherapy	_____
☐	☐	Seizure disorder	☐	☐	Hyperbaric oxygen	_____

Do you use tobacco products?_____ Dominant hand: _____

Is there any disease, condition or problem that we should be aware of?_____

Height:_____ Weight_____

Have you worn a prosthesis before? _____When/where was it fabricated? _____

Consent For Treatment:

I, the undersigned, request evaluation for a custom prosthesis as of this date. If I decide to proceed with design and fabrication of the prosthesis I agree to provide a physician's order prior to treatment. I have been provided with copies of the HIPAA policy and Patient's Bill of Rights. I hereby authorize Medical Art Resources, Inc., to publish, print, display or otherwise use photographs or models obtained in connection with my treatment for art, advertising, education, medical records or any other lawful purpose. Names will not be used or disclosed.

_____

Signature of Patient or Legal Representative / Date

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INSURANCE INFORMATION

MEDICARE **Are you covered by Medicare? YES** ☐ **NO** ☐

Is Medicare Primary? _____ Medicare Number _____

Do you have supplemental insurance? _____ Permanent state of residence? _____

Are you enrolled in a Medicare Advantage or other plan? _____ If yes, what is the name of plan: _____

Address _____ Telephone Number _____

City, State, Zip _____

Resident of Skilled Nursing Facility? _____ Name/address of facility _____

PRIMARY INSURANCE **Are you covered by private or employer provided health insurance? YES** ☐ **NO** ☐

Insurance Company _____ Telephone _____

Address _____ City, State, Zip _____

Employer or Group Name _____ Group No _____

Insured's Identification Number _____

Insured's Name _____ Relationship to patient _____

Is pre-authorization necessary? _____ Insured Birth Date _____

SECONDARY INSURANCE **Do you have a supplemental or secondary insurance policy? YES** ☐ **NO** ☐

Insurance Company _____ Telephone _____

Address _____ City, State, Zip _____

Employer or Group Name _____ Group No _____

Insured's Identification Number _____

Insured's Name _____ Relationship to patient _____

Is pre-authorization necessary? _____ Insured Birth Date _____

MEDICAID **Are you enrolled in Medicaid? YES** ☐ **NO** ☐

Medical Art Resources, Inc. is only a provider for Wisconsin, Indiana and Arizona Medicaid programs

Is Medicaid primary? _____ Identification Number _____

What state of residence? _____

Are you enrolled in a Managed Care Plan? _____ Name of Plan: _____

Address _____ Telephone Number _____

City, State, Zip _____

I attest that the insurance information provided is true and complete. I authorize Medical Art Resources, Inc. to release any medical information necessary to prior authorize, submit insurance claims or appeals on my behalf. I authorize payment of medical benefits directly to Medical Art Resources, Inc. I understand that I am responsible for fees not covered by insurance.

Signature of Insured: _____ Date: _____

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HAS THE DEPARTMENT OF VETERANS AFFAIRS (DVA) AUTHORIZED AND AGREED TO PAY FOR CARE AT THIS FACILITY? YES ☐ NO ☐

VETERANS HOSPITAL _____ Telephone _____

Address _____ City, State, Zip _____

Social Security number _____ _____

Referring VA Physician _____ Telephone _____

WORKERS COMPENSATION INFORMATION

Was the illness/injury due to a work related accident/condition? YES ☐ NO ☐

Employer _____ Telephone _____

Address _____ City, State, Zip _____

Claim number _____ Date of injury _____

Insurance Company _____ Telephone _____

Address _____ City, State, Zip _____

Case Manager _____ Has the prosthesis been authorized? _____

LIABILITY INFORMATION

Was the illness/injury due to a non-work related accident? YES ☐ NO ☐

Name of liability insurer and responsible party _____ _____

Address _____ City, State, Zip _____

Insurance Claim number _____ Date of accident _____

Insurance Company _____ Telephone _____

Address _____ City, State, Zip _____

Case Manager _____ Has the prosthesis been authorized? _____

I attest that the insurance information provided is true and complete. I authorize Medical Art Resources, Inc. to release any medical information necessary to prior authorize, submit insurance claims or appeals on my behalf. I authorize payment of medical benefits directly to Medical Art Resources, Inc. I understand that I am responsible for fees not covered by insurance.

Signature of Insured: _____ Date: _____

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HIPAA Patient Consent Form

Our Notice of Privacy Practices 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 (PHI) 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 PHI about you for treatment, payment and health care operations. Your 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. Medical Art Resources, Inc. provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used in treatment, payment or health care operations.
- Medical Art Resources, Inc. has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- Medical Art Resources, Inc. reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but Medical Art Resources, Inc. does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will cease.
- Medical Art Resources, Inc. may condition receipt of services upon execution of this consent.

DO YOU GIVE OUR OFFICE PERMISSION TO DISCUSS YOUR MEDICAL AND FINANCIAL INFORMATION WITH ANOTHER PERSON OR ENTITY?

☐ NO

☐ YES, MEDICAL INFORMATION ONLY

☐ YES, FINANCIAL INFORMATION ONLY

☐ YES, MEDICAL AND FINANCIAL INFORMATION

If yes, please provide their name, relationship, and phone number.

Name:_____Relationship:_____

Phone number:_____

MAY WE LEAVE PERSONAL MEDICAL INFORMATION ON YOUR ANSWERING MACHINE/VOICEMAIL?

☐ YES ☐ NO If yes, phone number(s):_____

DO YOU PREFER TEXT MESSAGE FOR APPOINTMENT REMINDERS?

☐ YES ☐ NO If yes, phone number(s):_____

THIS CONSENT WAS SIGNED BY:

_____

Signature of Patient or Legal Representative / Date

_____

Printed name Legal Representative if other than Patient / Date

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WELCOME

We would like to take this opportunity to extend our warm welcome, as you become a part of our office. Your needs and concerns are very important to us. Please take this time to review our office policy regarding financial arrangements and insurance reimbursement as they pertain to you.

PRIOR AUTHORIZATION/PRIOR NOTIFICATION

At your request we will submit a prior authorization request to your insurance provider. We require a physician's order that includes a statement of medical necessity. Once your prosthesis/treatment plan is authorized, a change in your insurance plan will require a new authorization and may delay your treatment.

PRE-DETERMINATION OF BENEFITS

We suggest that you contact your insurance carrier to understand coverage for your prosthesis. We will provide you with the diagnosis codes, procedure codes, and fees for the services you require, to assist with your inquiry. At your request, we will submit a pre-determination of benefits to your insurance company. However, we cannot guarantee the information we receive from your insurance company regarding deductibles and co-payments because insurance companies include disclaimers about the information they provide. If claims are not paid according to predetermination of benefits, we will supply supporting documentation to assist you with filing an appeal.

MEDICARE

Medical Art Resources, Inc. does not accept assignment on Medicare claims due to low allowable fees. We submit a claim to Medicare on your behalf. Medicare will send the check to you; therefore payment is expected at the time the prosthesis is delivered. If this creates a hardship, please talk with us so that special arrangements can be made. We may choose to accept assignment on individual claims. You have been provided a copy of the Center for Medicare and Medicaid Supplier Standards attached to this form.

MANAGED CARE AND PRIOR AUTHORIZATION—INCLUDING MEDICARE ADVANTAGE AND MEDICAID HMO PLANS

Without prior authorization or the appropriate referral form, services may not be covered. It is the patient's responsibility to satisfy the requirements of their managed care provider. We will submit a prior authorization to your managed care plan at your request. You will be 100% financially responsible for charges if the appropriate referrals are not obtained.

NETWORK PARTICIPATION

The services we offer are highly specialized. If your insurance company does not offer a network provider for the prosthetic services you require, you may request that the insurance company waive the out-of-network payment provision, and allow charges for services to be paid at the in-network payment level. It is wise to explore this in advance and understand your benefits. We are currently part of several provider networks.

PAYMENT ARRANGEMENTS

Based on your insurance pre-determination we expect payment when the prosthesis is complete for your anticipated portion of the cost. We accept MasterCard and Visa. In cases of hardship, please speak with us so that payment arrangements can be made.

OVERDUE ACCOUNTS

Accounts not paid by the primary insurance within 45 days of submission will become the patient's immediate responsibility. Any portion paid by the carrier thereafter will be reimbursed to you immediately. Failure to pay your account in full will result in a service charge of 1.5% on the unpaid balance per month thereafter starting 30 days from the date of the first statement.

COLLECTION

If your account is submitted to small claims court or attorneys for recovery of payment due for services provided, the patient agrees to pay all costs incurred, including actual attorney fees as well as all statutory Court costs and fees whether or not a formal judgment is entered against the patient.

Signature of Patient or Legal Representative / Date

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PRIVACY PRACTICES

We are committed to the protection of patient health information in accordance with applicable law and accreditation standards regarding patient privacy. The health information about you is personal. A record of the care and services you receive at Medical Art Resources, Inc. is needed to provide you with the quality care and to comply with legal requirements. A brochure with a full disclosure of our privacy practices is available in our office.

GOALS

A prosthesis is an artificial device used to replace a missing part of the body. The prosthesis benefits the patient by restoring absent anatomy. Additional functional benefits vary by the type of prosthesis. Each prosthesis is custom made from medical and health grade materials. Patient satisfaction is primary and every effort is made to satisfy the patient. A follow up appointment is typically scheduled 1-3 weeks after delivery of the prosthesis to insure satisfaction. A patient satisfaction survey will also be sent to you.

LIMITATIONS

As an artificial substitute for living tissue, a prosthesis has limitations. Unfortunately the technology is not yet available that will enable the prosthesis to change in coloration to match your changing complexion. The prosthesis does not grow or age. It must be removed daily to be cleaned, and to allow for cleaning of the underlying skin. Periodic replacements are necessary to maintain acceptable aesthetics and hygiene of the prosthesis and underlying tissue.

FOLLOW-UP CARE

Please call us with any problems or concerns—your satisfaction is important to us. You should return to our office within a few weeks for a follow up appointment. Patients with implant-retained prostheses should return to our office every 6 months to check peri-abutment tissue. Annual appointments are suggested for all patients for thorough cleaning and possibly color touch-up of the prosthesis. This can prolong the useful life of your prosthesis, which is expected to be 1-3 years.

GUARANTEE/WARRANTY

Your custom-made prosthesis is guaranteed for 90 days from date of delivery. We honor all warranties expressed and implied under applicable State law. If there is a defect or problem, which does not result from abuse of the prosthesis, the prosthesis will be replaced or repaired without charge within 90 days of delivery. If the patient is not satisfied with the prosthesis for any reason, he/she should call immediately to schedule an evaluation appointment. Medical Art Resources, Inc. will make every effort to provide a prosthesis that is acceptable to the patient.

MODIFICATIONS

If modifications are necessary, they will be provided without charge within 90 days of delivery. After 90 days, charges may be incurred for modifications. If additional surgery or tissue change necessitates modifications or a new prosthesis, then charges may be incurred. Charges will be based upon time and materials.

REPAIRS

Please do not attempt repairs yourself. Consult us immediately for repairs, which can prolong the useful life of your prosthesis. Repairs needed due to flaws in materials, components, or our manufacturing processes are provided without charge for 90 days from delivery. If repairs are needed due to improper handling or damage from an accident, then repairs will be billed on the basis of time and materials. If the patient or someone else attempts repairs or modifications, then Medical Art Resources, Inc. is no longer responsible for the prosthesis.

RETURNS

If Medical Art Resources, Inc. is unable to satisfy the patient, the prosthesis can be returned within 90 days of delivery and all collected fees will be refunded to the appropriate payer. The prosthesis must be physically returned. Verbal or written expression of dissatisfaction is not accepted as return.

I understand the information provided on this two-sided disclosure and agree to the office policies and procedures.

Signature of Patient or Legal Representative / Date

Printed name Legal Representative if other than Patient / Date

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PATIENT BILL OF RIGHTS

A health care client has the right to be informed of their rights and responsibilities before the initiation of care/services. If a client has been judged incompetent, the client's family or guardian may exercise these rights as described below. Below is the information given to our client's:

CLIENT RIGHTS, you have the right:

1. To receive services appropriate to your needs and expect the health care organization to provide safe, professional care at the level of intensity needed, without unlawful restriction by reason of age, sex, race, creed, color, national origin, religion or disability.
2. To have access to necessary professional services 24 hours a day, 7 days a week.
3. To be informed of services available.
4. To be informed of the ownership and control of the organization.

CLIENT CARE, you have the right:

1. To be involved in your care planning, including education of the same, and to be informed in a reasonable time of anticipated for completion of the service.
2. To receive reasonable continuity of care.
3. To be informed of your rights and responsibilities in advance concerning care and treatment you will receive including any changes, the frequency of care/service and by whom (disciplines) services will be provided.
4. To be informed of the nature and purpose of any technical procedure that will be performed, including information about the potential benefits and burdens as well as who will perform the procedure.
5. To receive care/service from staff who are qualified through education and/or experience to carry out the duties for which they are assigned.
6. To be referred to other agencies and/or organizations when appropriate and be informed of any financial benefit to the referring agency.

RESPECT AND CONFIDENTIALITY, you have the right:

1. To be treated with consideration, respect, and dignity, including the provision of privacy during care.
2. To have your property treated with respect.
3. To have staff communicate in a language or form you can reasonably be expected to understand and when possible, the organization assists with or may provide special devices, interpreters, or other aids to facilitate communication.
4. To maintain confidentiality of your clinical records in accordance with legal requirements and to anticipate the organization will release information only with your authorization or as required by law.
5. To be informed of the organization's policies and procedures for disclosure of your clinical record.

FINANCIAL ASPECTS OF CARE, you have the right:

1. To be informed of the extent to which payment for the health care services may be expected from Medicare, Medicaid or any other payer.
2. To be informed of changes not covered by Medicare and/or responsibility for any payment(s) that you might have to make.
3. To receive this information orally and in writing before care is initiated and within 30 calendar days of the date the organization becomes aware of any changes.

SELF-DETERMINATION, you have the right:

1. To refuse all or part of your care/treatment to the extent permitted by law and to be informed of the expected consequences of said action.
2. To have the organization comply with advance directives as permitted by state law and state requirements.
3. To be informed of the organization's policies and procedures for implementing advance directives.
4. To receive care whether or not you have an advance directive(s) in place, as well as not to be discriminated against whether or not you have executed an advance directive(s).
5. To not participate in research or not receive experimental treatment unless you give documented, voluntary informed consent.
6. To be informed of what to do in an emergency.
7. To participate in consideration of ethical issues that may arise in your care.

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COMPLAINTS, you have the right:

1. To voice complaints/grievances about treatment or care that is (or fails to be) furnished, or regarding lack of respect for property without reprisal or discrimination for it and be informed of the procedure to voice complaints/grievances with the home care organization. Complaints or questions may be registered with JULIE JORDAN BROWN in person or in writing. The address: Medical Art Resources, Inc., 3400 S. 103RD ST. SUITE 200, MILWAUKEE, WI 53227 and phone 414-543-1002. The organization investigates the complaint and resolution of it.
1. The State of WISCONSIN DEPARTMENT OF HEALTH SERVICES phone number for complaints or questions is 608-266-9369. The days and times of operation are Monday through Friday 9:00 a.m. to 5:00 p.m., except closed government agency holidays. A written complaint can be sent to the Wisconsin Department of Health Services, Client Rights Office, P.O. Box 7851, Madison, WI 53707-7851

CLIENT RESPONSIBILITIES

As a client, you have the responsibility:

1. To provide complete and accurate information about illness, hospitalization, medications, and other matters pertinent to your health; any changes in address, phone, or insurance/payment information; and changes made to advance directives.
2. To inform the organization when you will not be able to keep you appointment.
3. To treat the staff with respect.
4. To participate in and follow your plan of care.
5. To provide a safe environment for care to be given if care is provided in your home.
6. To cooperate with staff and ask questions if you do not understand instruction or information given to you.
7. To assist the organization with billing and/or payment issues to help with processing third party payment.
8. To inform the organization of any problems or dissatisfaction with services.

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Milwaukee, WI 53227
414-543-1002

HIPAA--Your Information, Your Rights, and Our Responsibilities

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

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

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.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**

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- We will not retaliate against you for filing a complaint.

YOUR CHOICES

We never market or sell your information. We may use and share your information as we:

For certain health information, you can tell us your choices about what we share.

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you. *Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary. *Example: We use health information about you to manage your treatment and services.*

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities. *Example: We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

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Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective 1/1/2017

Compliance officer: Julie Jordan Brown, MAMS, CCA phone: 414-543-1002
email: info@medicalartresources.com