AMERICAN ORTHOPEDICS

Required Documentation

For Diabetic Foot Orthoses / Extra Depth Shoes

Thank you for contacting American Orthopedics for your healthcare needs. Most insurances require certain documentation before coverage can be provided. If insurance is to be billed, you must obtain and bring the following information with you to your appointment. Cash-pay customers may skip steps 1-3.

What You Need To Do...

1 Call your Prescribing Doctor

Name _____

Phone _____

Request the following documentation:

- ☐ **Your signed prescription**
- ☐ **The doctor's clinical notes from the day of your prescription** (doctor's dictation, not the after-visit summary)

2 Call the doctor who Treats Your Diabetes*

*M.D. or D.O. Only

Name _____

Phone _____

Request the following documentation:

- ☐ **Your signed therapeutic shoe form** (template attached)
- ☐ **The doctor's clinical notes from your most recent encounter** (within the last 6 mos.)

3 For Additional Assistance

☐ Type bit.ly/shoedoc into your web browser to review a 3-min tutorial.

4 Bring ALL OF THE ABOVE documentation to your appointment

along with your ☐ Photo ID, ☐ Copy of Insurance, and ☐ Confidential Personal Information packet (completed). If any documentation is missing, the appointment will need to be rescheduled.

Documentation may be submitted in advance by mail to 1151 W 5th Ave, Columbus, OH 43212.

We appreciate your confidence in American Orthopedics and look forward to assisting with your healthcare needs.

COLUMBUS
1151 W. 5TH AVE.
COLUMBUS, OH 43212
614-291-6454 FAX 614-291-2874

MARION
1459 MARION WALDO RD.
MARION, OH 43302
740-375-9100 FAX 614-291-2874

SPRINGFIELD
2200 N. LIMESTONE ST., #108
SPRINGFIELD, OH 45503
937-342-0150 FAX 937-342-0170

Ohio Department of Medicaid

CERTIFICATE OF MEDICAL NECESSITY: THERAPEUTIC FOOTWEAR FOR INDIVIDUALS WITH DIABETES

Identifying Information [This section may be completed by the provider.]

Individual	Prescriber	Provider
Name	Name	Name American Orthopedics, Inc
Medicaid ID number	Medicaid provider number	Medicaid provider number
Date of birth	NPI	NPI
	Telephone number	

Certification [This section may be transcribed by the provider.]

Mark all items that apply.

Diagnosis code(s)

- ☐ This individual has diabetes mellitus.
- ☐ The following conditions of coverage are met.
  - ☐ An entire foot (i.e., the foot for which footwear is not being prescribed) has been amputated.
  - ☐ Part of either foot has been amputated.
  - ☐ In either foot, the individual has a history of
    - ☐ ulceration.
    - ☐ pre-ulcerative calluses.
    - ☐ peripheral neuropathy with evidence of callus formation.
    - ☐ foot deformity.
    - ☐ poor circulation.
- ☐ This individual is being treated for diabetes under a comprehensive plan of care by the prescriber.
- ☐ Therapeutic footwear is medically necessary for this individual because of diabetes.
- ☐ All relevant information is documented in this individual's medical record.

Comments or clinical information

Attestation [This section must be completed by the prescriber.]

I hereby attest that the certification information above is true, correct, and complete.	
Signature of prescriber	Date of signature

False certification constitutes Medicaid fraud.

Confidential Personal Record

AMERICAN ORTHOPEDICS

Patient:_____ Home:_____

Address:_____ Cell:_____

City:_____ State:_____ ZIP:_____

Email:_____ DOB:_____ SSN:_____

Sex: ☐ M ☐ F Ethnicity:_____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Emergency Contact:_____ Phone:_____

Relationship: ☐ Spouse ☐ Parent/Guardian ☐ Son/Daughter ☐ Friend ☐ Other:_____

*Primary Care Physician:_____ Phone:_____

*Prescribing Physician:_____ Phone:_____

*Diabetic Physician (if applicable):_____ Phone:_____

*Primary Insurance:_____ Phone:_____

*Secondary Insurance (if applicable):_____ Phone:_____

Resident of Nursing Facility? ☐ No ☐ Yes:_____ Phone:_____

BWC or Work Injury? ☐ No ☐ Yes, Claim No.:_____ Injury Date:_____

If yes, Employer:_____ Phone:_____

Address:_____

Is Patient a Minor? ☐ No ☐ Yes, Parent/Guardian:_____ Phone:_____

Address (if different than above):_____

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I certify this information is true and correct to the best of my knowledge. I will notify American Orthopedics, Inc. of any changes in my insurance status or the above information. I understand, in case of default, I will be responsible for all fees associated with the collection of this account.

I understand that American Orthopedics, Inc. will fill the prescription from my physician as written. Other than slight modifications for comfort, they will not alter the basic prescription without direct orders from the physician. The professional staff at American Orthopedics, Inc. is comprised of licensed Orthotists and Prosthetists. As such, they provide, but do not prescribe, orthotic and prosthetic care.

_____ _____

Patient Signature (or Parent/Legal Guardian if a minor) Date

Patient Medical History

AMERICAN ORTHOPEDICS

Patient:_____

☐ There have been NO CHANGES to my Medical History SINCE MY LAST VISIT. (Sign and date below.)

Medical Complications (check all that apply):

☐ Arthritis ☐ Diabetes ☐ Edema ☐ Heart Disease

☐ Mental Disease ☐ Obesity ☐ Ulcers, callusing ☐ Serious visual impairment

☐ Other:_____

Have you had any previous surgeries related to your present condition(s)? ☐ No ☐ Yes, _____

_____

_____

_____

Are you currently wearing an orthosis? ☐ No ☐ Yes, _____

_____

Site of Amputation (if applicable):

☐ Above left knee ☐ Above right knee ☐ Below left knee ☐ Below right knee

☐ Other:_____

Surgeon:_____

Facility:_____

Date of Amputation:_____

Date previous prosthesis provided:_____ Company provided prosthesis:_____

I certify this information is true and correct to the best of my knowledge. I will notify American Orthopedics, Inc. of any changes to the above information.

_____ _____

Patient Signature (or Parent/Legal Guardian if a minor) Date

Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment or Health Care Operations

I, _____ (please print), understand that as part of my healthcare, American Orthopedics, Inc. originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals

I have been given a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this Consent
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that American Orthopedics, Inc. is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this Consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that American Orthopedics, Inc. reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should American Orthopedics, Inc. change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, e-mail).

I wish to have the following restrictions to the use or disclosure of my health information:

_____

I wish to be contacted in the following manner:

		OK to leave message	OK to leave call-back number ONLY
Home phone		☐	☐
Cell phone		☐	☐
Work phone	( )		
Email			

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax and/or other electronic transmission. I understand and accept the terms of this Consent.

_____ _____

Patient Signature (or Parent/Legal Guardian if a minor) Date

Financial Arrangements & Medical Insurance

AMERICAN ORTHOPEDICS

PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED unless payment arrangements have been approved in advance by our Finance Manager. We accepted CASH, CHECKS, and MAJOR CREDIT CARDS.

The invoice you receive at your visit provides all the information you will need to file a claim for reimbursement from your insurance company. We will be happy to assist you in processing your insurance forms for reimbursement. Any such request must be accompanied by a completed insurance form for each visit.

In some cases, we will file your insurance claims for you. However, you are responsible for all co-payments and deductibles.

***** WE CANNOT ACCEPT ASSIGNMENT FOR CLAIMS OF LESS THAN $100.00 *****

***** A FEE OF $25.00 WILL BE ASSESSED FOR EACH RETURNED CHECK *****

Our fees for service are generally considered to fall within the acceptable range by most companies and therefore are covered up to the maximum allowable determined by each carrier.

This applies only to companies who pay a percentage (such as 50% or 80%) of "UCR". UCR is defined as "Usual, Customary and Reasonable" fee for this region. Thus, our fees are considered usual, customary and reasonable by most insurance companies. This statement does not apply to companies who reimburse based on an arbitrary "Schedule" of fees, which bears no relationship to the current standard and cost of care in this area. **NOT ALL SERVICES WE PROVIDE ARE COVERED BENEFITS.** Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that, as medical care providers, **our relationship is with you, not your insurance company.** As a service to you, our office will submit claims to your insurance company. However, you are ultimately responsible for the account. If temporary financial problems arise that may affect timely payment of your account, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us for assistance.

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered.

Patient Signature (or Parent/Legal Guardian if a minor) _____ Date _____

Authorization to Disclose Information

AMERICAN ORTHOPEDICS

Regarding Patient:_____ DOB:_____

Requesting from Facility:_____

Please read the entire form before signing below.

The purpose of this signed authorization is to help determine eligibility for benefits, including looking at the combined effect of any impairments that by themselves would not meet your insurance company's definition of eligibility for coverage and payment. American Orthopedics, Inc. may need to secure medical documentation from one or more of your physicians in order to provide your insurance company with the specific details they require in order to process your claim more quickly and accurately.

I, _____ (please print), voluntarily authorize and request disclosure of all my medical records, including written, oral and electronic, or other information related to my ability to perform tasks pursuant to my PROSTHETIC and/or ORTHOTIC TREATMENT and CARE with American Orthopedics, Inc., 1151 West 5th Avenue, Columbus, Ohio 43212. This includes specific permission to release:

1. All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s), including but not limited to:
    - Progress notes
    - Information relating to and including prescriptions
    - Hospital notes
2. Information about how my impairment(s) affects my ability to complete tasks and activities of daily living and affect my ability to work and enjoy life.
3. Information created within twelve (12) months after the date this authorization is signed, as well as past information.

Please sign using blue or black ink only.
Individual authorizing disclosure:

_____ _____
Patient Signature Date

_____ ☐ Parent ☐ Guardian ☐ POA
Authorized Signer

_____ _____
Witness (if needed) Date

Address:_____
Street City State ZIP County

NOTICE OF PRIVACY PRACTICES

Effective Date of this notice: January 29, 2014

Our Commitment to Protecting Your Privacy

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.

You do not need to respond to this notice in any way.

Our Responsibilities and Privacy Commitment

We understand the importance of protecting your private information. Our highest priority is to maintain your trust and confidence. We will maintain our commitment to safeguarding your information now and in the future.

We are required by law to:

- Maintain the privacy of your personal information
- Provide you with certain rights with respect to your personal information
- Provide you with a copy of this Notice of our legal duties and privacy practices with respect to your personal information
- Follow the terms of the Notice that is currently in effect.

We are guided by our respect for the confidentiality of your personal information. We are providing you with this notice in accordance with privacy laws and because we want you to know that we value your privacy.

Information We Collect

Personal Information is any information we obtain about you in the course of providing services. The information we may obtain includes, but is not limited to, your past, present, or future physical condition, the provision of health care to you, payment for the provision of healthcare to you, your Social Security number.

Our Privacy and Security Procedures

Our employees who have access to this information are those who must have it to provide products or services to you. Below are some examples of our guidelines for protecting information.

- Paper copies, when used, are viewed, discussed, and retained in private surroundings.
- Individuals viewing information stored in a computer must have passwords to gain access. Passwords are provided only to individuals who must have access to provide products or services to our patients.
- Our business associates use information only for the purpose provided. Business associates sign a contract agreeing to follow our privacy procedures.

Information We Disclose

We will not disclose any Personal Information about you, except as allowed by law, including the Fair Credit Reporting Act. We may share all of the information we collect with medical practices, insurance companies, agents, companies that help us to conduct our business, companies that are self-insured, or others as permitted by law. Below are examples of the times we may share information for business purposes:

- Submitting claims
- For purposes of treatment, payment, and operations, including assessment of eligibility, case management activities, coordination of care, collection of premium, payment of benefits, and other claims administration.
- With a regulatory, law enforcement, or other government authority as required by law. This may include finding or preventing criminal activity, fraud, material misrepresentation or material nondisclosures in connection with a medical issue.
- In response to an administrative or judicial order, including a search warrant or subpoena.

- With a medical care institution or professional, to verify coverage, conduct an audit of their activities, discuss a medical problem of which the insured may not be aware, and other purposes permitted or required by law.
- To consult with outside health care providers, consultants and attorneys, and other health related services.
- As otherwise permitted or required by law.

We require those with whom we share information to implement appropriate safeguards regarding your Personal Health Information. We share only that which is minimally necessary to accomplish a task. Information that we get from a report made by a company that assists us to conduct insurance business may be retained by that company and used for other purposes.

Your written authorization is required for uses and disclosures of Personal Information for purposes other than those described above. If you provide us authorization to use or disclose your Personal Information, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose information for the specific purpose contained in the authorization. We are required to retain any records we may have containing your Personal Information for the periods specified in document retention laws. If you revoke your authorization for payment or health care operations, you may jeopardize the administration of the benefits under your health plan.

Your Rights

Upon written request, you have the right to:

- Inspect and copy certain Personal Information. We may charge a reasonable fee for the costs of copying or mailing.
- Receive confidential communication of Personal Information.
- Request restrictions on certain uses and disclosures of your Personal Information, although we are not required to agree to a requested restriction.
- Request an amendment to your Personal Information, although we are not required to agree to an amendment.
- Receive an accounting of impermissible Personal Information disclosures or disclosures made in compliance with federal law (or state regulations, if applicable) for which an accounting is required.
- Be notified of a breach of unsecured Personal Information.

The written request must reasonably describe the information. The information requested must be reasonably locatable and retrievable.

How to File a Complaint Regarding the Use and Disclosure of Personal Information

If you believe your privacy rights have been violated, you may file a complaint with us, your respective state insurance department, or with the Secretary of Health and Human Services. All complaints must be in writing.

You may not be retaliated against for filing a complaint.

How to Contact Us

You may contact our representative at the following address:

Privacy Officer
Privacy Request
American Orthopedics, Inc.
1151 W. 5th Avenue
Columbus, OH 43212-2529

Notification of a revised privacy notice will be provided through one of the following:

- U.S. Postal Service
- Revised Plan Document

Any right a consumer, patient, or beneficiary may have under this notice is not limited by any other privacy notice used by American Orthopedics, Inc.