HORIZON PROSTHETICS LLC

Impacting Lives Through Quality Patient Care

Privacy restrictions or other patient requests:

Demographic Sheet

PATIENT INFORMATION

LAST NAME: FIRST NAME: M:

ADDRESS: APT: CITY: STATE: ZIP:

SEX: DATE OF BIRTH: EMAIL:

HOME PHONE: CELL PHONE: WORK PHONE:

How would you like to receive your invoice/receipt? (Circle all that apply) Email Paper Text

Would you like to receive an appointment reminder via text? (Circle one) YES NO

Can we leave a message on your answering machine? (Circle one) YES NO

*****Please circle the telephone number where we can best reach you or leave a message*****

SPOUSE/RESPONSIBLE PARTY – INFORMATION

LAST NAME: FIRST NAME: M:

RELATIONSHIP:

EMERGENCY CONTACT: MAIN PHONE:

PRIMARY INSURANCE: SECONDARY INSURANCE:

INSURANCE ID: INSURANCE ID:

ASSIGNMENT AND RELEASE: I hereby certify that the above information is true and correct to the best of my knowledge. I hereby assign my insurance benefits to be paid directly to Horizon Prosthetics. I am financially responsible for **ALL NON-COVERED** services. I also authorize that physician to release any information required to process my claim to insurance company.

X

(Signature of patient or parent/guardian if minor) (Date)

I give permission for my medical information or test results to be released to the following people:

1. Relationship:
2. Relationship:

Horizon Prosthetics
Phone: 303-660-1238
Fax: 303-872-6528

CUSTOMER INFORMATION CHECKLIST AND ACKNOWLEDGEMENT

☐ **Customer Rights and Responsibilities** (see separate handout)
☐ **Medicare Supplier Standards** (see separate handout)
☐ **HIPAA Privacy Notice** (see separate brochure)
☐ **Acceptance of Services**

I understand that by signing this agreement, I authorize provision of products and/or services to me by Horizon Prosthetics. I also understand the products and services provided are prescribed by my physician and that it is necessary that I remain under the supervision of my attending physician during the course of care.

☐ **Release of Information**

I hereby authorize release to your company of any and all of my medical records pertaining to my medical history, services rendered, or treatments received from my physician(s) or hospital. **In** order to process insurance claims, I also hereby authorize Horizon Prosthetics to furnish my insurance carriers(s), and medical history, services rendered, or treatment needed. I further authorize Horizon Prosthetics, the accreditation organizations, and other licensing bodies to periodically examine my records for the purpose of checking compliance to regulations and quality assurance requirements.

☐ **Assignment of Benefits**

I authorize direct payment of insurance benefits by my insurance company to Horizon Prosthetics. In the event that my insurance carrier does not accept assignments of benefits, I understand that my payments may be sent directly to me and that I am obligated to endorse and directly send such payments to Horizon Prosthetics.

☐ **Financial Responsibility**

I understand and I acknowledge that I am responsible to Horizon Prosthetics for all charges not covered by my insurance. I recognize that in the event that my insurance company, employer, or any other third-party payer refuses to pay the rental and/or purchase price(s) of the received items, or delayed payments beyond 90 days of my receipt of items, or in the event that I have no insurance coverage or third-party payer, that I will be responsible for said payments and will make prompt reimbursement within 30 days of notification by Horizon Prosthetics for all charges. ***Horizon Prosthetics cannot guarantee patient insurance benefits including but not limited to coinsurance and deductible amounts provided by insurance and it is the patient's responsibility to verify their own benefits.***

☐ **Equipment Warranty Information and Return Policy**

Each manufacturer has their own policies regarding warranties, returns and repairs on their products. Please contact Horizon Prosthetics with any questions regarding warranty, returns, or repairs, and we will evaluate each situation along with the manufacturer on a case by case basis. We follow manufacture guidelines. Horizon Prosthetics retains 15% of total price as a restocking fee on all returns.

☐ **Complaint Policy**

All customers have the right to lodge complaints without fear of discrimination or reprisal and to know the disposition of complaints. Horizon Prosthetics has the responsibility to respond to those complaints promptly and to resolve complaints whenever possible to the satisfaction of the individual. (See Right and Responsibilities handout)

☐ **Custom Orthotics and Braces**

Custom orthotics and braces will be billed at the time of delivery. In the event I do not pick them up when ready, I understand they will be billed to my insurance or me, if my insurance does not pay I am responsible.

☐ **Change In Insurance Benefits and Coverage**

I understand it is my responsibly to disclose any changes to my medical insurance coverage or benefits to Horizon Prosthetics at the time of the measurement. I understand by signing I am stating to my knowledge there are no changes in my insurance.

☐ **I understand Horizon Prosthetics' delivery and follow-up procedures**

I acknowledge, understand and receive the entire contents of this document.

Patient Signature	Date	Print Name
Signature of authorized representative for patient	Date	Print Name

Parent/Guardian MPOA
Other: _____

HORIZON PROSTHETICS, LLC

Financial Responsibility Agreement

PATIENT RESPONSIBILITY:

Any fees collected at the time of service and any quotes regarding such fees are **estimated,** based on the information available to us at the time of service. We rely on information provided by the responsible party regarding insurance coverage and information from the responsible party's insurance company. It is the patient's responsibility to provide current, accurate insurance plan information for all plans that you are requesting us to bill for your products and services, including notifying us of insurance changes before services are provided, so we may authorize services and request eligibility, benefits and coverage allowed by your plan. *There are many factors that may affect insurance information provided and while we will make every effort to provide accurate information, your insurance will not guarantee the information provided to us, and we cannot guarantee insurance information.* ***Patient is ultimately responsible for payment and we strongly advise you to verify your benefits information with your insurance as it is the patient's responsibility to understand their individual insurance benefits.***

PAYMENT ARRANGEMENTS:

Patient responsibility estimate is due before products will be ordered or payment arrangements are available upon request. `````` Please ask about this option if you are interested.

BILLING PRACTICES:

We will bill your insurance company and collect any co-insurance, co-pay, deductibles. The responsible party will be billed for any remaining charges not covered by insurance. Additionally, the responsible party will be billed for charges denied by insurance due to lack of incident/accident reporting, Lack of insurance coverage/retroactive termination of coverage, non-covered or non-authorized products and services. We will bill you for any amount remaining due or refund any over payment, between the amount collected and amounts due. If your maximum benefit allowed per the plan year has been met for products and services, you are responsible if not paid by your insurance. Please be advised that patient responsibility (PR) payment amounts due may change due to, but not limited to, yearly resetting deductibles, plan changes, eligibility at time of service.

COLLECTION ACTIVITY:

Any account balance not paid within 90 days of the date of service may be forwarded to an outside agency for collection follow up. Any account balance that remains unpaid after this transfer may be reported to the credit bureaus.

Signature:_____ Date:_____

Return Policy:

We follow manufacture guidelines for returns and exchanges. Each manufacturer has their own policies regarding warranties, exchanges, returns and repairs on their products, not to exceed 30 days. Please contact Horizon Prosthetics with any questions regarding warranty, exchanges, returns, or repairs, and we will evaluate each situation along with the manufacturer on a case by case basis. Horizon Prosthetics retains 15% of total price as a restocking fee on returns.
All returns must be in unused, unopened condition and be made to a Horizon Prosthetics office, and a return form signed and consultation/description of why item is being returned. Products that have been worn are not eligible for return or exchange unless there is a manufacturer defect.
Horizon Prosthetics must be notified of any product manufacturer defect within 7 days of delivery and return of product to Horizon made within manufacturer guidelines.

Custom braces or other custom devices and products are not eligible for returns.

Refund Policy:

Horizon Prosthetics (Provider), will refund any overages of monies collected for claims as appropriate after the explanation of benefits (EOB) from all insurances and payments have been made by all parties being billed for the complete claim. The EOB accompanies the payment from insurance payers and it is the payer's instructions to the Provider of how to process the claim, including the patient responsibility amounts and must be received in order for our office to determine any refund due. Once all explanation of benefits and payment for the complete claim is received by Horizon Prosthetics, refunds, if any, will be processed within 30 days. It is our policy to refund the original method of payment unless requested in writing a different payment method or the original method is unavailable. Refunds will be processed after all payments have been *received* by Horizon Prosthetics.

Patient Name_____

Patient Signature_____ Date: _____