

PROSTHETIC PATIENT INTAKE SHEET

NAME _____

DATE _____

ADDRESS _____

SSN _____

E-MAIL _____

AGE _____ DOB _____

PHONE # HOME _____ WORK _____ CELL _____

EMER CONTACT _____ EMER PHONE _____

MARITAL STATUS/KIDS _____ OCCUPATION _____

INSURANCE INFORMATION

INSURANCE COMPANY _____

INSURANCE CO ADDRESS:

INSURANCE PHONE:

INSURANCE ID #

EMPLOYER

WORK PHONE

WORK ADDRESS

PHYSICIAN NAME

PHYSICIAN PHONE & FAX #

PHYSICIAN ADDRESS

MEDICAL HISTORY

DATE OF AMPUTATION _____ LAST X-RAY _____

REASON FOR AMPUTATION _____

PRIOR SURGERY _____

REASON FOR VISIT _____

TEMPORARY PRO _____ PERMANENT PRO _____ PRE SURG CONSULT _____

LEFT _____ RIGHT _____ BILAT _____

LEVEL OF AMPUTATION: AK BK SYMES BE

 HIP DIS HEMI AE

HEIGHT _____ WEIGHT _____ SHOE SIZE _____

GOALS, PHYSICAL ACTIVITY/LIMITATIONS _____

LIST ALL MEDICATIONS _____

PRIOR PROSTHETIST Y N NAME _____

PHYSICAL THERAPY Y N NAME _____

PAST MEDICAL HISTORY

HAVE YOU BEEN TREATED FOR ANY OF THE FOLLOWING?
IF YES, PLEASE EXPLAIN.

<input type="checkbox"/> HEART	<input type="checkbox"/> LUNG DISEASE	<input type="checkbox"/> LIVER
<input type="checkbox"/> KIDNEY	<input type="checkbox"/> ULCERS	<input type="checkbox"/> POOR CIRCULATION
<input type="checkbox"/> BLOOD PRESSURE	<input type="checkbox"/> ARTHRITIS	<input type="checkbox"/> PSORIASIS
<input type="checkbox"/> SEIZURES	<input type="checkbox"/> STROKE	<input type="checkbox"/> ANEMIA
<input type="checkbox"/> BLOOD CLOTS	<input type="checkbox"/> PSYCHIATRIC	<input type="checkbox"/> HEPATITIS - A, B, C
<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> THYROID	<input type="checkbox"/> ASTHMA
<input type="checkbox"/> ANXIETY	<input type="checkbox"/> DEPRESSION	<input type="checkbox"/> DIABETES
<input type="checkbox"/> BLEEDING DISORDER		
<input type="checkbox"/> CANCER	TYPE _____	
<input type="checkbox"/> INFECTIONS	TYPE/WHERE _____	

EXPLAIN ABOVE _____

HOW DID YOU HEAR ABOUT A STEP AHEAD? _____

SIGNATURE _____

PRINT _____

DATE _____

A STEP AHEAD PROSTHETICS & ORTHOTICS

PATIENT/CLIENT BILL OF RIGHTS

As an individual receiving orthotic and prosthetic services from our Company, let it be known and understood that you have the following rights:

1. To select those who provide you orthotic and prosthetic services.
2. To receive the appropriate or prescribed service in a professional manner without discrimination relative to your age, sex, race, religion, ethnic origin, sexual preference or physical or mental handicap.
3. To be dealt with and treated with friendliness, courtesy and respect by each and every individual representing our Company who provides treatment or services for you, and be free from neglect or abuse, be it physical or mental.
4. To assist in the development and planning of your health care program that is designed to satisfy, as best as possible, your current needs.
5. To be provided with adequate information from which you can give your informed consent for the commencement of service, the continuation of service, the transfer of service to another health care provider, or the termination of service.
6. To express concerns or grievances or recommend modifications to your service without fear of discrimination or reprisal.
7. To request and receive complete and up-to-date information relative to your condition, treatment, alternative treatments, or risks of treatment.
8. To receive treatment and services within the scope of your health care plan, promptly and professionally, while being fully informed as to our company's policies, procedures, and charges.

9. To refuse treatment, within the boundaries set by law, and receive professional information relative to the ramifications or consequences that will or may result due to such refusal.
10. To request and receive data regarding treatment or services or costs thereof privately and with confidentiality.
11. To request and receive the opportunity to examine or review your medical records.

I have received and understand the rights afforded me as a patient/client.

Signature of Patient/Client

Date

Signature of Practitioner

Date

A STEP AHEAD PROSTHETICS & ORTHOTICS
AUTHORIZATION AND RELEASE

I, (printed name) _____ do hereby irrevocably consent to and authorize A Step Ahead, LLC (“ASA”), it’s members, agents, employees, and personnel who are acting on behalf of ASA to use my photograph or other likeness for purposes related to the promotion, publicity, and marketing of ASA, without compensation to me.

I understand my photograph or other likeness may be copied and distributed by means of various media including but not limited to placement on the ASA website, other electronic delivery or publications, video presentations, print brochures, mailings, and for display inside ASA offices and facilities.

I acknowledge that ASA has the right to make one or more photographs, audio, video, recordings, or other electronic reproductions of my image, voice or performance in accordance with this agreement. I waive any right to inspect or approve the finished product, or any material in which ASA may eventually use the photographs.

I relinquish and give ASA all rights, title and interest in and to the photographs, including any copyright therein. This consent and release shall be binding upon my heirs, successors, assigns and legal representations.

I understand that although, ASA will endeavor to use my photograph or likeness in accordance with standards of good judgment, ASA cannot warrant or guarantee that any further dissemination of my photograph or likeness will be subject to ASA supervision or control. Accordingly, I release ASA from any and all liability related to dissemination of my photograph or likeness, reproduction, distribution, and display of the photographs in print or any and all other media, and any alteration, distortion or illusionary effect, whether intentional or otherwise, in connection with said use.

I also understand that upon my written request, I may revoke this Authorization at anytime and ASA will cease from further reproducing my photograph or video image or other likeness for any further purpose. However, I understand that my right to revoke this Authorization does not extend to ASA uses of my photograph or other likeness that have already been created prior to the date of written notice of my revocation of this authorization.

I have read and understand the conditions of this consent form.

Signature of Patient or Parent/Guardian

Age (if minor)

Date

Printed or Typed Name

Phone

Address

City/State/Zip

**CONSENT OF PARENT/LEGAL GUARDIAN
REQUIRED IF ABOVE INDIVIDUAL IS A MINOR**

I am the parent and/or legal guardian of the above minor and hereby consent and agree to the foregoing terms and provisions on his or her behalf.

Signature

Date

Printed or Typed Name

Phone

Address

City/State/Zip

A STEP AHEAD PROSTHETICS & ORTHOTICS, LLC.

CANCELLATION POLICY

1. We call all of our clients 24 to 48 hours beforehand to confirm upcoming appointments. If we do not receive a positive confirmation the day before the scheduled appointment, we reserve the right to cancel it and substitute a client who is on our emergency stand-by list.
2. If you are more than 15 minutes late for your scheduled appointment, we reserve the right to cancel it.
3. This policy is designed to protect the quality of treatment that you expect and deserve by ensuring that our prosthetists have an appropriate amount of time to focus on your care. When a patient shows up late for an appointment, it causes a snowball effect that pushes everyone else in the schedule back. We strive to see every patient at the time that they made their appointment so that they can minimize the amount of time spent at our facility. Please take the measures necessary to ensure that you reach A Step Ahead at or before your scheduled appointment time.
4. I have read and understand A Step Ahead's Cancellation Policy. I understand that if I fail to confirm my appointment or show up more than 15 minutes late the day of my appointment, that appointment may be cancelled by A Step Ahead.

**A STEP AHEAD PROSTHETICS & ORTHOTICS
CLIENT PAYMENT ACKNOWLEDGEMENT FORM**

A Step Ahead is committed to providing you the highest-quality prosthetic and orthotic care. If you have any questions about our professional fees, please speak to our Insurance Task Force. Your understanding of our Financial Policy is important to our relationship.

1. Coinsurance & Deductible

I acknowledge my responsibility to pay any applicable co-insurance and deductible to A Step Ahead in a timely fashion.

2. Balances

The difference between what A Step Ahead bills and what an insurer may reimburse can result in a balance due. Insurers reimburse at their “usual and customary rate”. The “usual and customary” rate generally is based upon what prosthetists/orthotists in the same general geographic area bill to their patients. The insurer’s “usual and customary rate” may be the same as or lower than A Step Ahead’s charges. Your insurer’s “usual and customary rate” does not supersede A Step Ahead’s charge, and any difference between what your insurer pays and A Step Ahead’s charge may be the patient’s responsibility.

I acknowledge my responsibility to pay any and all unpaid balances to A Step Ahead in a timely fashion.

Date

**HIPAA PRIVACY PRACTICES NOTICE
ACKNOWLEDGEMENT FORM**

I have received and thoroughly reviewed A Step Ahead Prosthetics & Orthotics Notice of Privacy Practices. I understand that the privacy notice details how my protected health information ("PHI") can be used by A Step Ahead, what my rights are, and what A Step Ahead's duties are to me to protect my PHI.

Signature (if the guardian of a minor patient,
please also indicate relationship to that minor)

Print Name

Date: _____

**A STEP AHEAD PROSTHETICS & ORTHOTICS
NOTICE OF PRIVACY PRACTICES**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION
ABOUT YOU MAYBE USED AND DISCLOSED AND HOW
YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.**

YOUR PROTECTED HEALTH INFORMATION (“PHI”)

PHI means individually identifiable health information that is transmitted by electronic media, maintained in any electronic media, or transmitted or maintained in any other form or medium.

HOW A STEP AHEAD CAN USE YOUR PHI

A Step Ahead is permitted to use your PHI to: (a) provide you treatment (e.g., disclosing your PHI to a physician so that he or she can safely treat you); (b) obtain payment for the services we render (e.g., disclosing your PHI to an insurance company to establish medical necessity); and (3) for health care operations (e.g, utilizing your PHI in A Step Ahead’s business planning, development, and management).

A Step Ahead is also permitted to utilize your PHI to send you appointment reminders. A Step Ahead may also disclose your PHI to a family member, friend, or other person to the extent necessary to help with your health care or with payment for your health care. Your name, location, and general condition or death may be used or disclosed to notify or assist in the notification of a person involved in your care.

A Step Ahead may disclose your PHI to another covered entity or a health care provider for the payment activities of the entity that receives the information. A Step Ahead may disclose PHI to another covered entity for health care operations activities of the entity that receives the PHI, if each entity either has or had a relationship with the individual who is the subject of the PHI being requested, the PHI pertains to that relationship, and the disclosure is for the individual’s treatment, payment, health care operations, or for the purpose of health care fraud and abuse detections or compliance.

If a member of A Step Ahead’s workforce or a business associate engages in whistleblowing (i.e., discloses specific PHI to statutorily-listed authorities with the good-faith belief that A Step Ahead has engaged in unlawful conduct, or has otherwise violated professional or clinical standards, or has provided care, services, or conditions that endanger one or more patients, workers, or the public), PHI disclosure in that context will not be considered a violation of HIPAA’s privacy requirements.

Any other uses or disclosures will be made only with your written authorization, and you may revoke your authorization at any time. Your revocation must be in writing.

YOUR RIGHTS

You have the right to request restrictions on certain uses and disclosures of your PHI. We may ask you to submit your request in writing. We will review your request, but we are not required to comply with it.

You have the right to receive confidential communications of PHI from A Step Ahead by alternative means or at alternative locations as long as the request for that PHI is reasonable. We may ask you to submit your request in writing.

You have the right to inspect or obtain a copy of the medical information about you that is contained in a “designated record set” for as long as the PHI is maintained in the designated record set. We may ask you to submit your request in writing. A Step Ahead has the right to deny access to the designated record set in certain statutorily-defined instances. If we deny access to the designated record set, you will have the right to have the denial reviewed.

You have the right to request that A Step Ahead amend your PHI in a designated record set for as long as the PHI is maintained in the designated record set. A Step Ahead may ask you to submit your requested amendment in writing.

You have the right to receive an accounting of disclosures of your PHI for the 6 years prior to the date on which the accounting is requested.

A STEP AHEAD'S DUTIES

A Step Ahead is required by law to maintain the privacy of your PHI and to provide you with notice of our legal duties and privacy practices with respect to your PHI. We have a privacy program in place that meets the requirements of the Health Insurance Portability and Accountability Act ("HIPAA") Privacy Regulations, the Federal legislation that sets standards for the privacy of your PHI.

A Step Ahead is required to abide by the terms of this privacy notice while it remains in effect. A Step Ahead reserves the right to change the terms of this privacy notice and to make new notice provisions effective for all PHI that it maintains. If A Step Ahead does revise this privacy notice, it will provide the revised notice to you in writing.

COMPLAINTS

Individuals may complain to A Step Ahead and to the Secretary of the U.S. Department of Health and Human Services if it believes that there has been a failure to honor your privacy rights. Any complaint to A Step Ahead should be sent to A Step Ahead's then-current business address, presently 132 Newbridge Rd., Hicksville, New York, 11801. If you elect to file a complaint against A Step Ahead, we will not retaliate against you in any way.

CONTACT

If you have any questions about this privacy notice, please contact A Step Ahead's President, Erik Schaffer, at 516.681.3484.

This privacy notice is effective as of April 14, 2003.

Attention Patients!!!

New A Step Ahead Policy:

Please be advised that effective immediately you must sign in AND sign out!!

Before you leave the facility you now must initial the sign-in sheet after every appointment. When you are delivered any item(s), you must sign a delivery sheet that states all the items you were delivered. **THIS IS YOUR RESPONSIBILITY!!** If you do not sign a delivery sheet, you become liable. Not signing could void warranties and/or make you accountable for costs and payments.

Please remember that when you receive ANY new item, you must sign for it. If you are unsure if you have to sign, please ask at the front desk or step into the billing department and someone will be able to advise you of your responsibility.

If you have any questions regarding this policy, please do not hesitate to ask!!

Patient Signature: _____

Date: _____