PATIENT COMMON WORKING FORM- MUST BE COMPLETED EACH YEAR BY PATIENT OR REPRESENATIVE.

Date: _____ Name of Representative Completing Form: _____

Patient Information

Name: _____ Phone: _____

Address: _____ City: _____ ST: _____ ZIP: _____

DOB: _____ SS#: _____

Insurance Information

Primary Insurance: _____

Primary Policy #: _____ Primary Phone #: _____

Claims Address: _____

Supplemental Insurance: _____

Supplemental Policy #: _____ Supplemental Phone #: _____

Physician Information

Name: _____ NPI#: _____

Address: _____ City: _____ ST: _____ ZIP: _____

Phone: _____ Fax: _____

OUTCOME

Qualifying Records: _____

Scheduled Fitting: _____

SC DL Copied: _____ **Insurance Cards Copied:** _____ **Insurance Verified:** _____

7001 St. Andrews Rd A-17 Columbia, SC 29212 800.484.4627 (p) 866.771.6123 (f)

HIPAA Act of 1996

Notice of Patient Privacy Practices

This notice describes how medical information about the patient may be used, disclosed and how to gain access to this information. Please review carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires all medical information and individually identifiable health information used or disclosed by us in any form, electronic, paper or orally are kept properly confidential. This Act gives you, the patient significant new rights to understand and control how your health information is used. *We may use and disclose your records for each of the following purposes: Treatment, Payment and Health care Operations (Definitions are available upon request) Detailed HIPAA, Medicare standards and Patient's Rights are found at* ***www.solutionsorthocare.com)***

We may contact you about supply alternatives, other health related benefits and services that may be of interest. We may disclose medical information to family members or caregivers. We may disclose medical information when required to do so by federal, state or local law or to an oversight agency for activities authorized by law.

Any other uses or disclosures will be made only with your written authorization. You may revoke such authorization and we are required to honor and abide by that written consent. You have rights with respects to your Protected Health Information. We are required by law to maintain the privacy of your protected health information and provide to you with notice of our legal duties and privacy practices with respects to protected health information. We will notify you in the case of any breach of your Protected Health Information.

This notice takes effect immediately and we are required to abide to the terms of this privacy notice. You have recourse if you feel your privacy protections have been violated. You have the right to file a written complaint with our office or the Department of Health and Human Services.

I, _____ have read and acknowledged the above HIPAA Privacy Act of 1996 statement
(SIGNATURE) and have received a copy of the web link and/or hard copy of the Foot Solutions HIPAA Notice of Privacy Practices for Personal Health Information. I authorize my physician to share medical information with Solutions Orthocare Group.

Date: _____

AUTHORIZATION OF BILLING

I, _____ authorize the use of my insurance information to **bill** for *SERVICES RENDERED or TO BE RENDERED VIA PRIOR AUTHORIZATIONS, PRE-DETERMINATIONS & RE-DETERMINATIONS.* I understand that my insurance(s) may decide to not pay for stated services. I agree to be held responsible for services and/or covered items submitted to my primary insurance and/or secondary insurance with adequate documentation. I understand that a claim will be submitted to my primary insurance and/or secondary insurance on my behalf and payment assignment will be accepted by Solutions Orthocare Group, LLC. Any co-payments or deductibles due after payment has been made are my responsibility unless other arrangements have made at time of delivery.

I, _____ *have read and acknowledged the above authorization of billing. Date:* _____
(SIGNATURE)

Statement of Certifying Physician

Therapeutic Shoes for Persons with Diabetes

(The certifying physician must be the M.D. or D.O. caring for the patient's diabetic condition and may be different from the prescribing physician)

Effective January 1, 2011: For Therapeutic Shoes for Persons with Diabetes to be covered by Medicare, the patient's medical record must contain sufficient documentation about the patient's medical condition to substantiate the qualifications and medical necessity for the type and quantity of items ordered and for the frequency of use or replacement (if applicable). This form affirms that the Certifying Physician has completed such documentation.

Patient Name: _____ **Date of Birth:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone Number: _____ **MBI (HICN)#:** _____

I certify that all of the following statements are true and hereby attest that this medical record entry accurately reflects signatures/notations that I made in my capacity as an MD or DO when I treated/diagnosed the beneficiary listed above.

1) This patient has Diabetes Mellitus **(CIRCLE PRIMARY ICD-10: E10.40 E10.42 E10.49 E10.50 E10.610 E10.621 E10.8 E10.9 E11.40 E11.42 E11.49 E11.59 E11.610 E11.621 E11.69 E11.8 E11.9 E13.40 E13.42 E13.49 E13.610 E13.621 E13.69 E13.8 E13.9)**

2) This patient has one or more of the following conditions: **(CHECK OFF THEN CIRCLE ICD-10 CODES THAT APPLY)**

- ☐ History of Partial or Complete Foot Amputation **(Z89.4 Z89.411 Z89.412 Z89.419 Z89.421 Z89.422 Z89.429)**
- ☐ Foot Deformity **(M20.10 M20.40 M20.41 M20.42 M20.20 M20.5X1 M20.5X2 M20.5X9 M21.37 M21.40 M21.53 M21.54)**
- ☐ History of Pre-Ulcerative Callous **(L84 L97.401 L97.411 L97.421 L97.429 L97.501)**
- ☐ Poor Circulation **(I70.201 I70.202 I70.203 I70.291 I70.292 I70.293 I87.2)**
- ☐ Peripheral Neuropathy **with** Callous Formation **(E08.42 G57.70 G60.0 G62.9 & L84)**
- ☐ Previous Ulcer(s) **(L97.401 L97.402 L97.403 L97.404 L97.409 L97.421 L97.422 L97.423 L97.424)**

NOTE: If you check one or more of these conditions; it must be clearly documented in the patient's medical records

3) I am treating this patient under a comprehensive plan of care for his/her diabetes.

4) This patient needs extra depth shoes with multi density inserts because of his/her diabetes.

Certifying Physician Signature: _____ **Date:** _____

Name (Printed): _____ **NPI Number:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____

Standard Written Order (SWO) Therapeutic Shoes/Inserts for Persons with Diabetes

(Prescribing Physician may be an M.D., D.O., or D.P.M., physician assistant, nurse practitioner, clinical nurse specialist and may be different than certifying physician)

Patient Name: _____ **Date of Birth:** _____

Date of Office Visit: _____ **Start Date:** _____ **PATIENT NEEDS DIABETIC SHOES & CUSTOM ORTHOTICS**

Select All Applicable:

- ☐ One pair (2 units or 1 RT, 1 LT) of depth inlay shoes **(A5500)**, Fitting (including follow up), custom preparation and supply of off-the shelf depth inlay shoo manufactured to accommodate multi-density insert(s), per shoe.
- ☐ Three pair (6 units) of custom inserts **(A5513))** multiple density insert, custom molded from model of patient's foot, total contact with patient's foot, including arch, base layer minimum of 3/16" material of shore A 35 durometer or higher, includes arch filler and other shaping material, custom fabricated, each; **OR (A5514)** multiple density insert, made by direct carving with cam technology from a rectified cad model created from a digitized scan of the patient, total contact with patient's foot, including arch, base layer minimum of 3/16" material of shore 35 durometer or higher, includes arch filler and other shaping materials, custom fabricated
- ☐ Partial foot, shoe insert with longitudinal arch, toe filler **RT** or **LT**. **(L5000)**
- ☐ One pair (2 units) of ankle orthosis, ankle gauntlet or similar compressive support **(L1902)** w/ without joints, prefabricated, off-the-shelf
- ☐ One unit (1 **RT** or 1 **LT**) bunion night splint, off-the-shelf. **(L3100)**
- ☐ One unit (1 **RT** or 1 **LT**) extra depth heel cup, off-the-shelf or fabricated. **(L3170)**

Physician: I certify that I am the prescribing physician. I have reviewed this SWO and confirmed the items prescribed & diagnosis are accurate.

Prescribing Physician Signature: _____ **Date:** _____

Name (Printed): _____ **NPI:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

SOLUTIONS ORTHOCARE

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PLEASE FAX BACK TO NUMBER ABOVE