SHAW'S PROSTHETICS PLUS, INC.

1019 OLD HARTFORD ROAD
OWENSBORO, KY 42303
PHONE: 270-684-7672 FAX 270-684-7094

INSTRUCTIONS FOR COMPLETING NEW PATIENT INFORMATION

1. Complete the WHITE *Patient Information Sheet*. Sign and date at the bottom.
2. Sign the small GREEN *Notice of Privacy Practices Receipt*.
3. Keep the WHITE *Notice of Privacy Practices* (4 pages).
4. We will need a copy of your insurance cards.
   Cardholder's full name: _____
   Cardholder's Social Security Number: _____
5. If this is a Worker's Compensation Claim we will need the following information:

   Insurance Company: _____
   Where you worked: _____
   Date of accident: _____
   How did the accident happen: _____
   What is your claim number: _____
   What number do we call to verify coverage: _____
   Who is your claims adjustor: _____

METHOD OF PAYMENT

1. We will verify your insurance coverage and will file your claim for you. We **DO NOT** guarantee payment by any insurance company. Co-insurance and deductible amounts are expected upon delivery and any bills received at a later date are to be paid within 30 days of receipt of invoice. By signing this form you state that you understand any invoices sent to you that go unpaid over 30 days will be sent to a collection agency. This is to be considered your notice.
2. We accept major credit cards.
3. We accept cash or personal checks.
4. We offer Care Credit with no interest installment payments for up to one year. If you have any questions regarding Care Credit our office staff will be more than happy to explain how this works.

Remember: ***YOU*** are responsible for your account along with any co-payments and/or deductibles. We will make every effort to collect from your insurance carrier. If they do not pay we will look to you for payment in full by using one of the above mentioned methods of payment.

X _____ DATE _____

Signature of responsible party

Today's Date: _____/_____/2012

Referring Physician:_____

Diagnosis: _____ ☐ right ☐ left

Date of Injury: _____ Cause:_____

_____

SHAW'S PROSTHETICS PLUS, INC.

PATIENT REGISTRATION FORM

PATIENT INFO

Patient Name: _____
(first) (middle/maiden) (last)

Address: _____
(street) (city) (state) (zip code)

Home phone: _____ Cell phone: _____

Soc. Sec. # _____-_____-_____ Age: _____ Birthdate: _____/_____/_____

☐ Male ☐ Female HEIGHT_____ WEIGHT_____ Shoe size: _____ (applies to lower extremity patients)

Your Employer: _____ Phone:_____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

If Married, Spouse's Name _____

EMPLOYER INFO

Spouse's Employer:_____Phone:_____

If Patient is a Minor – Father's name _____Mother's Name_____

Emerg. Contact: _____ Rel. _____ Phone:_____

Is this visit pertaining to a Workers' Comp accident? ☐ No ☐ Yes If yes Date of accident ____/____/_____

Description: _____

Employer: _____

BILLING INFO

Send account information to Or leave message with: ☐ home address ☐ work/office ☐ E-mail @ address _____

☐ answering machine ☐ other specify)_____

Permission to discuss my account with: (privacy regulation) ☐ myself ☐ spouse ☐ parent if child or dependent

☐ insurance and/or Workers' Comp. Carrier

☐ personal representative(s) (specify) _____

_____

My signature indicates the above information is true to the best of my knowledge. I authorize the release of medical or other information necessary to Shaw's Prosthetics Plus, Inc., for orthotic and/or prosthetic treatment. I also authorize release of information necessary for insurance claim filing purposes.

I understand not all items may be covered by my insurance policy. Coverage verification with my insurance carrier does not guarantee a payment from them. It is my responsibility to provide Shaw's Prosthetics Plus, Inc with up-to-date insurance information. I also understand I am ultimately responsible for any allowed amount not paid for or covered by insurance.

X_____ Date: _____/_____/2012

2012

Dominant side: ☐ right handed ☐ left handed

Sensation: right side: ☐ good ☐ poor

Left side: ☐ good ☐ poor

Are you currently taking physical therapy? ☐ Yes ☐ No

If Yes, where: _____

Name of P/T: _____

Have you received the same or similar item as prescribed by your physician today in the past 5 years?

☐ Yes ☐ No

If yes, when? _____

From whom? _____

ENVIRONMENTAL STATUS (check all that apply)

☐ Use steps/stairs on a daily basis

☐ Access to elevator

☐ Walk / run on uneven terrain (hilly or rocky area)

☐ Need assistance walking or other daily activities

☐ Use following walking aids:

☐ wheelchair ☐ walker ☐ cane ☐ crutches

ALLERGIES (check all that apply)

☐ Rubber

☐ Latex

☐ Metal (type) _____

☐ Adhesives _____

☐ Material (wool, cotton, etc.) _____

_____

REVIEW OF SYSTEMS (check all that apply)

☐ **Diabetes**

☐ Insulin dependent

☐ Oral medication controlled

☐ Diet controlled

☐ Name of diabetic physician:

_____

☐ **Heart disease** _____

☐ **High Blood Pressure**

☐ **Arthritis**

☐ Osteoarthritis ☐ Rheumatoid

☐ **Osteoporosis**

☐ Kyphosis (severely rolled shoulders)

☐ Scoliosis (curvature of spine)

☐ Chronic Back Pain

☐ Chronic leg pain ☐ right. leg ☐ left leg

☐ **Amputation(s)**

☐ Toes

How many? _____ ☐ right foot ☐ left foot

☐ Partial foot ☐ right foot ☐ left foot

☐ Complete foot ☐ right foot ☐ left foot

☐ Below-the-knee ☐ right leg ☐ left leg

☐ Above-the-knee ☐ right leg ☐ left leg

☐ Fingers

How many? _____ ☐ right hand ☐ left hand

☐ Partial hand ☐ right hand ☐ left hand

☐ Complete hand ☐ right hand ☐ left hand

☐ Below-the-elbow ☐ right arm ☐ left arm

☐ Above-the-elbow ☐ right arm ☐ left arm

Excessive Weight fluctuation

☐ loss _____lbs. ☐ Gained _____lbs.

☐ **Senile dementia**

☐ **Alzheimer's disease**

☐ **Stroke** when: _____

☐ **TIA (mini-stroke)** when: _____

☐ **Parkinson's disease**

☐ **Cerebral Palsy**

☐ **Spina Bifida**

☐ **Visual impairment**

☐ Contacts? ☐ Eyeglasses?

☐ Blindness _____

☐ **Hearing impairment** ☐ right. ear ☐ left ear

☐ **Physical impairment** _____

☐ **HIV exposure**

☐ **Hepatitis B** ☐ **Hepatitis C**

☐ **MRSA**

☐ **Are you currently pregnant?** ☐ Yes ☐ No

If YES, how many months? _____

MAJOR ILLNESS / SURGERY HISTORY:

1. _____
2. _____
3. _____
4. _____
5. _____

Medications: _____

_____

_____

_____

Notice of Privacy Practices Receipt

Today's Date: _____/_____/_____

_____

Patient's Name

_____-_____-_____ _____/_____/_____

Social Security Number Patient's Date of Birth

X_____

Signature of patient or patient's personal representative

My signature above indicates I have received a copy of Shaw's Prosthetics Plus, Inc's "Notice of Privacy Practices." I understand that should any revisions be made to the privacy practices, I will be notified so I may obtain a copy of the revised edition.

NOTICE OF PRIVACY PRACTICES
FOR SHAW'S PROSTHETICS PLUS, INC.

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. We are required by law to ensure that any medical or health information received at this facility is kept private and the use or disclosure of this information is in accordance with this Notice of Privacy Practices and applicable law. We are required to give you this Notice of our legal duties and our privacy practices. We are required to abide by the terms of the Notice of Privacy Practices that are in effect at time of service.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your Protected Health Information may be used and disclosed by your Orthotist/Prosthetist, our office staff and others outside of our office involved in providing healthcare services to you. This information may be used/disclosed for your treatment, to pay your healthcare bills and to support the operation of this facility. *As examples*, we may use or disclose your Protected Health Information to:

1. Provide and manage your healthcare and related treatments and coordinate with your physician or other healthcare providers who may be treating you.
2. Allow us to use a sign-in sheet at the registration desk or call you by name in the waiting room.
3. Contact you for appointment scheduling or rescheduling purposes.
4. Support the business activities of this facility, such as (but not limited to) quality assessment, employee review, legal services, licensing and other business activities.
5. Share your Protected Health Information with third party Business Associates that perform various activities for this facility (i.e. fabrication labs, specialty item facilities, etc. involved in providing us with supplies, goods and inventory).
6. Obtain payment for your healthcare services.
7. Provide you with information regarding products or services we believe may be beneficial to you.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION BASED UPON YOUR WRITTEN AUTHORIZATION

1. Uses and disclosures of your Protected Health Information will be made only with your written authorization, unless otherwise permitted or required by law as described below.
2. You may revoke your authorization at any time, in writing. Understand any use/disclosure authorized by you prior to your revocation cannot be invalidated.
3. We are required to keep a record of medical care provided to you.
4. Authorization is a separate document. You will have the opportunity to review any authorization before you sign it.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES THAT MAY BE MADE EITHER WITH YOUR AGREEMENT OR THE OPPORTUNITY TO OBJECT

Based on your written authorization, we may disclose your Protected Health Information to an immediate family member, a relative, a close friend or any other person you identify, in so much as your information relates to that person's involvement in your health care.

If you are not present or if you are unable to agree/object to such a disclosure, we reserve the right to use/disclose information that is in your best interest. Under such circumstances, our decision will be made strictly on the basis of our professional judgment.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES THAT MAY BE MADE WITHOUT YOUR AUTHORIZATION OR OPPORTUNITY TO OBJECT

We may use or disclose your Protected Health Information in the following situations without your authorization or providing you the opportunity to object:

1. **Required by Law. This provision applies to federal, state or local law. The use/disclosure will be made in compliance with the law and limited to the relevant requirements of the law. Where required by law, you will be notified of such uses/disclosures.**

2. **Public Health. If permitted by law, we may disclose your Protected Health Information to a public health authority for the expressed purpose of controlling disease, injury or disability.**

3. **Communicable Diseases. If authorized by law, we may disclose your Protected Health Information to an individual who may have been exposed to a communicable disease or who may be at risk of contracting or spreading the disease or condition.**

4. **Health Oversight. We may disclose your Protected Health Information to a health oversight agency for the purpose of audits, investigations and inspections, as authorized by law.**

5. **Abuse or Neglect. We may disclose your Protected Health Information to an authorized public health authority if we believe one of our patients, regardless of age, gender or race, may have been or is a victim of abuse, neglect or domestic violence. The disclosure will be made either with your approval or as required by federal and/or state laws.**

6. **Military and Veterans. If you are a member of the military, we may release your Protected Health Information as required by military command authorities.**

7. **Food and Drug Administration. Should the Food and Drug Administration require it, we may disclose your Protected Health Information for the purposes of reporting adverse events, product defects or problems and/or biologic product deviations. This reporting may be used to track products, enable product recalls, make repairs or replacements, or conduct post-marketing surveillance. Your Protected Health Information will be reported only to a person or company authorized/specified by the Food and Drug Administration.**

8. **Legal Proceedings. We may disclose your Protected Health Information in the course of any judicial or administrative proceeding where one or both of the following conditions are present: (1) in response to a court order or administrative tribunal (to the extent such disclosure is expressly authorized), and/or (2) in certain conditions in response to a subpoena, discovery request, or other lawful process.**

9. **Law Enforcement. We may disclose your Protected Health Information for law enforcement purposes as long as applicable legal requirements are met.**

10. **Coroners, Funeral Directors and Organ Donation. We may disclose your Protected Health Information to a coroner, medical examiner and/or funeral director for purposes of (1) identification, (2) determining the cause of death, and/or (3) performing other duties authorized by law. Protected Health Information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.**

11. **Research. Under certain circumstances, we may disclose your Protected Health Information to researchers when their research has been approved by an institutional review board. In such cases, the institutional review board must have reviewed the research proposal and established protocols to ensure the privacy of your Protected Health Information.**

12. **Criminal Activity. As applicable with federal, state and/or local laws, we may disclose your Protected Health Information if we believe the use/disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose Protected Health Information if it is necessary for law enforcement authorities to identify or apprehend an individual.**

13. **Military Activity and National Security. When applicable, we may use/disclose Protected Health Information of individuals who are Armed Forces personnel, (1) for activities deemed necessary by appropriate military command authorities, and/or (2) in determining benefit eligibility by the Department of Veterans Affairs. We may also use/disclose Protected Health Information to a foreign military authority if you are a member of that**

foreign military service. We may disclose your Protected Health Information to authorized federal officials who are conducting national security and intelligence activities including protective services to the President of the United States or others legally authorized.

14. Workers' Compensation. We may disclose your Protected Health Information to comply with Workers' Compensation laws and other similar legally established programs that provide benefits for work related illnesses and injuries.

15. Inmate at Correctional Facility. We may use or disclose your Protected Health Information if you are an inmate of a correctional facility and your Orthotist/Prosthetist created or received your Protected Health Information in the course of providing care for you.

REQUIRED USES AND DISCLOSURES

Under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services. The Department of Health and Human Services may use the disclosure information to investigate or determine our compliance regarding the final rule on *Standards for Privacy of Individually Identifiable Health Information* requirements.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You may inspect and obtain a copy of your Protected Health Information contained in your medical records, billing records, and any other records that your Orthotist/Prosthetist uses for making decisions about you. You have this right for as long as we maintain the Protected Health Information.

To inspect or receive a copy of your medical information, you must submit a written request to the HIPPA Compliancy Officer within our office. If you request a copy of your information, we may charge you a fee for the costs of copying, mailing and other costs incurred by us in complying with your request. We reserve the right to comply within 60 days of your request, in the event the records have been archived or appropriate personnel are not available to comply with your request.

In limited situations specified by law, we may deny your request. In some circumstances, you may have the right to have this decision reviewed. The person conducting the review will not be the person who initially denied your request. We will comply with the decision in any review. Please contact our HIPAA Compliancy Officer if you have questions about access to your records.

YOU HAVE THE RIGHT TO REQUEST A RESTRICTION OF YOUR PROTECTED HEALTH INFORMATION

You may ask us not to use or disclose any part of your Protected Health Information. You will be required to complete the appropriate form, stating the specific restriction requested and to whom or under what circumstance(s) you want the restriction to apply.

SHAW'S PROSTHETIC PLUS, INC. IS NOT REQUIRED TO AGREE TO A RESTRICTION THAT YOU MAY REQUEST

If the Orthotist/Prosthetist believes it is in your best interest to permit use and disclosure of your Protected Health Information, then use/disclosure will not be restricted.

If your Orthotist/Prosthetist does agree to the requested restriction, we may not use or disclose your Protected Health Information unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your Orthotist/Prosthetist. You may request a restriction in writing, directed to the attention of the HIPAA Compliancy Officer at this facility.

YOU HAVE THE RIGHT TO RECEIVE CONFIDENTIAL COMMUNICATIONS FROM US BY ALTERNATIVE MEANS OR AT AN ALTERNATIVE LOCATION

We will accommodate *reasonable* requests. We reserve the right to place conditions on this request. For example, we may ask you for information as to how payment will be handled or specification of an alternative address or method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing, directed to the attention to the HIPAA Compliancy Officer at this facility.

YOU MAY HAVE THE RIGHT TO HAVE SHAW'S PROSTHETIC PLUS, INC. AMEND YOUR PROTECTED HEALTH INFORMATION

For as long as we maintain your Protected Health Information, you may request an amendment to that information contained in your medical, billing and any other records that your Orthotist/Prosthetist uses for making decisions about you. You must

make your request for amendment in writing, directed to the attention to the HIPAA Compliancy Officer and provide the reason(s) that support your request.

We reserve the right to deny any request that is (1) not in writing and (2) does not state a reason supporting the request. We reserve the right to deny your request for amendment of any information that:

- Was not created by us
- Is not a part of the Protected Health Information kept by or for us
- Is not part of the information you would be permitted to inspect or copy
- Is accurate and complete

If we deny your request for amendment, we will do so in writing with an explanation for the denial. You have the right to file a written statement of disagreement with us. We reserve the right to prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our HIPAA Compliancy Officer to determine if you have questions about amending your medical record.

YOU HAVE THE RIGHT TO RECEIVE AN ACCOUNTING OF CERTAIN DISCLOSURES WE HAVE MADE, IF ANY, OF YOUR PROTECTED HEALTH INFORMATION

This right only applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It also excludes disclosures we may have made to you, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You must submit a written request for disclosures, in writing, directed to the attention of the HIPAA Compliancy Officer. You must specify a time period, *not to exceed six years*, and *cannot include any date prior to April 14, 2003*. You have the right to *one, free* request within any 12-month period. We reserve the right to charge you for any additional requests in the same 12-month period. We will notify you about the charges you will be required to pay. You are free to withdraw or modify your requests, in writing, before any charges are incurred. Payment is due when the additional copy request is processed.

YOU HAVE THE RIGHT TO REVOKE YOUR CONSENT OF USE AND DISCLOSURE

As the patient, you have the right to withdraw your permission for SHAW'S PROSTHETICS PLUS, INC.'s use and disclosure of your Protected Health Information. If you decide to revoke your consent, you must do so in writing. The request must be signed either by yourself or your personal representative. Understand any use/disclosure authorized by you prior to your revocation cannot be invalidated. (As an example, SHAW'S PROSTHETICS PLUS, INC. reserves the right to pursue the processing of an insurance claim or the settlement of an account incurred prior to the revocation, etc.)

YOU HAVE THE RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE FROM US

You may obtain a copy of this Notice of Privacy Practices by written request, directed to the attention of our HIPAA Compliancy Officer.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our HIPAA Compliancy Officer of your complaint. SHAW'S PROSTHETICS PLUS, INC. will not take any retaliatory action against you should a complaint be submitted to our office or the Secretary of Health and Human Services. To file a complaint, respond to either:

Leigh Anne Ball, HIPAA Compliancy Officer
Shaw's Prosthetics Plus, Inc.
1019 Old Hartford Road
Owensboro, KY 42303
270/684-7672

Robinsue Frohboese, Acting Director
Office of Civil Rights
U.S. Dept. of Health & Human Services
200 Independence Avenue, S.W.
Room 509F - HHH Building, Washington, D.C. 20201

CHANGES TO THIS NOTICE

We reserve the right to change the privacy practices that are described in this *Notice of Privacy Practices*. We also reserve the right to apply these changes retroactively to Protected Health Information received before the change in privacy practices. You may obtain a copy of the revised *Notice of Privacy Practices* by requesting one either in writing or in person. This notice was published and becomes affective April 14, 2003.