MedicalArt Resources INC.

3400 S 103rd Street, Suite 200
Milwaukee, WI 53227
p: (414) 543-1002 f: (414) 543-0137

PATIENT REGISTRATION

Personal Information

Patient's Name ***Preferred Name*** **Date of Birth** **Home Phone**

Address **Work Phone** **Cell Phone**

City, State Zip **Email:**

Parent/Guardian Names (for minor patient) **Home Phone** **Cell Phone**

Emergency Contact **Phone**

Medical Information

Type of prosthesis needed

Prosthesis is needed due to ☐ **Birth difference** ☐ **Traumatic injury** ☐ **Disease and/or Surgery**

Diagnosis **Date of traumatic injury or surgery**

Referring Physician Name **Clinic Name** **Phone**

Address **City, State Zip**

Relevant medical history: please check yes (Y) or no (N)

Y	N	CONDITIONS	Y	N	HISTORY
☐	☐	Diabetes or circulatory problems	☐	☐	Keloid formation
☐	☐	Eczema/Psoriasis	☐	☐	Allergies ________________
☐	☐	Arthritis	☐	☐	Pacemaker
☐	☐	HIV + AIDS	☐	☐	Radiation therapy Date:________
☐	☐	MRSA, Hepatitis	☐	☐	Chemotherapy Date:________
☐	☐	Seizure disorder	☐	☐	Hyperbaric oxygen Date:________

Do you use tobacco products? Y N Height __________ Weight __________

Any other disease, condition, or problem that we should be aware of?______________________

Consent For Treatment:

I, the undersigned, request evaluation for a custom prosthesis as of this date. I have been provided with copies of the HIPAA policy and Patient's Bill of Rights. I hereby authorize Medical Art Resources, Inc., to publish, print, display or otherwise use photographs or models obtained in connection with my treatment for advertising, education, medical records or any other lawful purpose. Names will not be used or disclosed.

____

Signature of Patient, Parent, or Legal Representative / Date

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INSURANCE INFORMATION

MEDICARE: Complete this section if you are covered by Medicare. Is Medicare primary? Y N

State of residence ____________________________ Medicare ID Number: ____________________________

Is Medicare your primary insurance? Y N

Are you enrolled in Original Medicare with Part B? Y N

Are you a resident of a Skilled Nursing Facility? Y N

If yes, name of Facility ____

Are you enrolled in a Medicare Advantage plan? Y N ID # ____________________________________

If yes, name of Advantage plan ____ Group #____________________

INDIVIDUAL, MARKETPLACE OR EMPLOYER PLAN: Complete this section if you are covered by private insurance.

Insurance Co. __________________________________ ID # ______________________ Group #_____________

Address ____ City, State, Zip _________________________________

Employer or Group Name __________________________________ Phone ______________________________

Are you the Primary Insured on the plan? Y N If no, name of Primary Insured? ____________________

Primary Insured's ID # __________________________ Primary Date of Birth ____________________________

Your relationship to Primary Insured ___________________ Is pre-authorization necessary? Y N

SECONDARY INSURANCE: Complete this section if you have a supplemental or secondary insurance policy.

Insurance Co. __________________________________ ID # ______________________ Group #_____________

Address ____ City, State, Zip _________________________________

Employer or Group Name __________________________________ Phone ______________________________

Are you the Primary Insured on the plan? Y N If no, name of Primary Insured? ____________________

Primary Insured's ID # __________________________ Primary Date of Birth ____________________________

Your relationship to Primary Insured ___________________ Is pre-authorization necessary? Y N

MEDICAID: Complete this section if you are enrolled in a Medicaid program.
Medical Art Resources can only accept Wisconsin, Indiana, and Arizona Medicaid

Is Medicaid primary? Y N Medicaid ID # ____

Are you enrolled in a Managed Care Plan? Y N

If yes, Name of Plan ____ ID # ____________________________

Please provide a copy of the front and back of ALL applicable insurance cards.

I attest that the insurance information provided is true and complete. I authorize Medical Art Resources, Inc. to release any medical information necessary to predetermine benefits, prior authorize, submit insurance claims, or appeals on my behalf. I authorize payment of medical benefits directly to Medical Art Resources, Inc. I understand that I am responsible for fees not covered by insurance.

Signature of Responsible Party: Date:
____

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VETERAN'S BENEFITS: Complete this section if the prosthetic services you require are covered by the VA.

VETERANS HOSPITAL ______________________ Telephone ____________

Address ______________________ City, State, Zip ____________

Social Security number ______________________

Referring VA Physician ______________________ Telephone ____________

WORKERS COMPENSATION: Complete this section if you have an active claim with workers compensation insurance, due to a work-related injury that resulted in your need for a reconstructive prosthesis.

Employer ______________________ Telephone ____________

Address ______________________ City, State, Zip ____________

Claim number ______________________ Date of injury ____________

Insurance Company ______________________ Telephone ____________

Address ______________________ City, State, Zip ____________

Case Manager ______________________ Has the prosthesis been authorized? ____________

LIABILITY INFORMATION: Complete this section if you suffered an accident or injury that resulted in your need for a reconstructive prosthesis.

Insurance company ______________________ Claim number ____________

Address ______________________ City, State, Zip ____________

Telephone ______________________ Date of accident ____________

Please provide all relevant documentation for coverage.

I attest that the insurance information provided is true and complete. I authorize Medical Art Resources, Inc. to release any medical information necessary to prior authorize, submit insurance claims or appeals on my behalf. I authorize payment of medical benefits directly to Medical Art Resources, Inc. I understand that I am responsible for fees not covered by insurance.

Signature of Insured: ______________________ Date: ____________

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HIPAA Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information (PHI) about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of PHI about you for treatment, payment and health care operations. You have the right to revoke this Consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. Medical Art Resources, Inc. provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used in treatment, payment or health care operations.
- Medical Art Resources, Inc. has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- Medical Art Resources, Inc. reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but Medical Art Resources, Inc. does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will cease.
- Medical Art Resources, Inc. may condition receipt of services upon execution of this consent.

DO YOU GIVE OUR OFFICE PERMISSION TO DISCUSS YOUR MEDICAL AND FINANCIAL INFORMATION WITH ANOTHER PERSON OR ENTITY?

NO

YES, MEDICAL INFORMATION ONLY

YES, FINANCIAL INFORMATION ONLY

YES, MEDICAL **AND** FINANCIAL INFORMATION

If yes, please provide their name, relationship, and phone number.

Name: ______________________________ Relationship: ___________________________

Phone number: ___________________________

CAN WE LEAVE PERSON INFORMATION ON YOUR VOICEMAIL?

_____YES _____NO If yes, phone number(s): _________________________________

DO YOU PREFER TEXT MESSAGES FOR APPOINTMENT REMINDERS?

_____YES _____NO If yes phone number(s): __________________________________

THIS CONSENT WAS SIGNED BY:

____

Signature of Patient, Parent, or Legal Representative / Date

____

Printed name of Patient, Parent, or Legal Representative

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WELCOME
Your needs and concerns are very important to us. Please take this time to review our office policy regarding financial arrangements and insurance reimbursement as they pertain to you. There is no fee for the initial consultation.

PRE-DETERMINATION OF BENEFITS & PRIOR AUTHORIZATION
We will request benefit information from your insurance provider. We will provide a treatment plan that includes our fees, your anticipated insurance coverage, and estimated financial obligation. We cannot guarantee the information we receive from your insurance company regarding deductibles and co-insurance but will do our best to provide accurate information. When a prior authorization is required by your plan, we will submit a request for you. A physician's order and clinical notes from a recent appointment are required by insurance providers to support the medical necessity of your prosthesis. Once your prosthesis/treatment plan is authorized, a change in your insurance plan will require a new authorization and will delay treatment. **The delivery date for your prosthesis is the date of service for your insurance claim.** You must inform us immediately if your coverage lapses or changes before your delivery date. If claims are not paid according to predetermination of benefits, we will supply supporting documentation to assist you with an appeal.

MEDICARE (Does not apply to Medicare Advantage plans)
Medical Art Resources, Inc. does not accept assignment on Medicare claims for most services, due to low allowable fees. We will submit a claim to Medicare on your behalf, unless the service you require is not covered by Medicare. Claims for prosthetics go to a regional Medicare carrier if you have regular Medicare. Medicare will send a reimbursement check to you; therefore, payment is expected at the time the prosthesis is delivered. If this creates a hardship, please talk with us so that special arrangements can be made. We may choose to accept assignment on individual claims. You have been provided a copy of the Center for Medicare and Medicaid Supplier Standards attached to this form.

NETWORK PARTICIPATION
The services we offer are highly specialized. We are currently contracted with several provider networks, but unfortunately, we have not been able to negotiate a contract with every insurance carrier.

MANAGED CARE PLANS—including Medicare Advantage & Medicaid HMO, PPO Plans
Your insurance plan is a contract between you and the insurance carrier. It is the patient's responsibility to satisfy the requirements of their managed care plan. If Medical Art Resources is not in your network, it is important to know whether your plan includes out-of-network coverage. We do our best to advocate for coverage of your treatment plan.

PAYMENT
Your estimated financial obligation must be paid in full before your prosthesis is completed because **we are creating a custom prosthesis for you and the process is very time intensive.** We accept major credit cards and Care Credit (a credit card specific to health care). In cases of hardship, please speak with us so that payment arrangements can be made. We do not bill your insurance company until the prosthesis is complete. Any overpayments are promptly refunded when your insurance claim is processed.

BREAST PROSTHESES AND CUSTOM FACEGUARDS
Payment is required when the order for products in placed.

OVERDUE ACCOUNTS
Accounts not paid by your insurance plan(s) within 45 days of submission will become the patient's immediate responsibility. Failure to pay your account in full will result in a service charge of 1.5% per month on the unpaid balance, starting 30 days from the date of the first statement. If your account is submitted to small claims court or attorneys for recovery of payment due, the patient agrees to pay all costs incurred, including actual attorney fees as well as all statutory Court costs and fees whether or not a formal judgment is entered against the patient.

____

Signature of Patient or Legal Representative / Date

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PRIVACY PRACTICES

We are committed to the protection of patient health information in accordance with applicable law and accreditation standards regarding patient privacy. Your health information is personal. A record of the care and services you receive at Medical Art Resources, Inc. is needed to provide you with quality care and to comply with legal requirements. A brochure with a full disclosure of our privacy practices is available in our office.

GOALS

A prosthesis is an artificial device used to replace a missing part of the body. The prosthesis benefits the patient by restoring absent anatomy. Additional functional benefits vary by the type of prosthesis. Each prosthesis is custom made from medical and health grade materials. Patient satisfaction is primary, and every effort is made to satisfy the patient. A follow up appointment is typically scheduled 1-3 weeks after delivery of the prosthesis to ensure satisfaction. A patient satisfaction survey will also be sent to you.

LIMITATIONS

As an artificial substitute for living tissue, a prosthesis has limitations. Unfortunately, the technology is not yet available that will enable the prosthesis to change in coloration to match your changing complexion. The prosthesis does not grow or age. It must be removed daily to be cleaned, and to allow for cleaning of the underlying skin. Periodic replacements are necessary to maintain acceptable aesthetics and hygiene of the prosthesis and underlying tissue.

FOLLOW-UP CARE

Please call us with any problems or concerns—your satisfaction is important to us. You should return to our office within a few weeks for a follow up appointment. Patients with implant-retained prostheses should return to our office every 6 months to check peri-abutment tissue. Annual appointments are suggested for patients who wear a facial, hand or foot prosthesis for thorough cleaning and possibly color touch-up of the prosthesis. This can prolong the useful life of your prosthesis.

GUARANTEE/WARRANTY

Your custom-made prosthesis is guaranteed for 90 days from date of delivery. We honor all warranties expressed and implied under applicable State law. If there is a defect or problem, which does not result from abuse of the prosthesis, the prosthesis will be replaced or repaired without charge within 90 days of delivery. If the patient is not satisfied with the prosthesis for any reason, he/she should call immediately to schedule an evaluation appointment. Medical Art Resources, Inc. will make every effort to provide a prosthesis that is acceptable to the patient.

MODIFICATIONS

If modifications are necessary, they will be provided without charge within 90 days of delivery. After 90 days, charges may be incurred for modifications. If additional surgery or tissue change necessitates modifications or a new prosthesis, then we will provide a new treatment plan.

REPAIRS

Please do not attempt to repair your prosthesis. Consult us immediately for repairs, which can prolong the useful life of your prosthesis. Repairs needed due to flaws in materials, components, or our manufacturing processes are provided without charge for 90 days from delivery. If repairs are needed due to improper handling or damage from an accident, then repairs will be billed on the basis of time and materials. If the patient or someone else attempts repairs or modifications, then Medical Art Resources, Inc. is no longer responsible for the prosthesis and the warranty is void.

RETURNS

If Medical Art Resources, Inc. is unable to satisfy the patient, the prosthesis can be returned within 90 days of delivery, and all collected fees will be refunded to the appropriate payer. The prosthesis must be physically returned. Verbal or written expression of dissatisfaction is not accepted as return.

I understand the information provided on this two-sided disclosure and agree to the office policies and procedures.

____

Signature of Patient or Legal Representative / Date

____

Printed name Legal Representative if other than Patient / Date

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PATIENT BILL OF RIGHTS

A health care client has the right to be informed of their rights and responsibilities before the initiation of care/services. If a client has been judged incompetent, the client's family or guardian may exercise these rights as described below. Below is the information given to our clients:

CLIENT RIGHTS, you have the right:

1. To receive services, appropriate to your needs and expect the health care organization to provide safe, professional care at the level of intensity needed, without unlawful restriction by reason of age, sex, race, creed, color, national origin, religion or disability.
2. To have reasonable access to necessary professional services Monday-Friday, with a phone number for urgent needs.
3. To be informed of services available.
4. To be informed of the ownership and control of the organization.

CLIENT CARE, you have the right:

1. To be involved in your care planning, including education of the same, and to be informed of anticipated completion of the service.
2. To receive reasonable continuity of care.
3. To be informed of your rights and responsibilities in advance concerning care and treatment you will receive including any changes, the frequency of care/service and by whom (disciplines) services will be provided.
4. To be informed of the nature and purpose of any technical procedure that will be performed, including information about the potential benefits and burdens as well as who will perform the procedure.
5. To receive care/service from staff who are qualified through education and/or experience to carry out the duties for which they are assigned.
6. To be referred to other agencies and/or organizations when appropriate and be informed of any financial benefit to the referring agency.

RESPECT AND CONFIDENTIALITY, you have the right:

1. To be treated with consideration, respect, and dignity, including the provision of privacy during care.
2. To have your property treated with respect.
3. To have staff communicate in a language or form you can reasonably be expected to understand and when possible, the organization assists with interpreters, or other aids to facilitate communication.
4. To maintain confidentiality of your clinical records in accordance with legal requirements and to anticipate the organization will release information only with your authorization or as required by law.
5. To be informed of the organization's policies and procedures for disclosure of your clinical record.

FINANCIAL ASPECTS OF CARE, you have the right:

1. To be informed of the extent to which payment for the health care services may be expected from Medicare, Medicaid or any other payer.
2. To be informed of charges not covered by Medicare, Medicaid or any other payer and/or responsibility for any payment(s) that you might have to make.
3. To receive this information orally and in writing before care is initiated and when the organization becomes aware of any changes.

SELF-DETERMINATION, you have the right:

1. To refuse all or part of your care/treatment and to be informed of the expected consequences of said action.
2. To have the organization comply with advance directives as permitted by state law and state requirements.
3. To not participate in research or not receive experimental treatment unless you give documented, voluntary informed consent.
4. To be informed of what to do in an emergency.
5. To participate in consideration of ethical issues that may arise in your care.

(continued on reverse side)

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COMPLAINTS, you have the right:

1. To voice complaints/grievances about treatment or care that is (or fails to be) furnished, or regarding lack of respect for property without reprisal or discrimination for it and be informed of the procedure to voice complaints/grievances with the home care organization.
2. Complaints or questions may be registered with JULIE JORDAN BROWN in person or in writing. The address: Medical Art Resources, Inc., 3400 S. 103RD ST. SUITE 200, MILWAUKEE, WI 53227 and phone 414-543-1002. The organization will investigate the complaint and inform you of the resolution.
1. The State of WISCONSIN DEPARTMENT OF HEALTH SERVICES phone number for complaints or questions is 608-266-9369. The days and times of operation are Monday through Friday 9:00 a.m. to 5:00 p.m., except closed government agency holidays. A written complaint can be sent to the Wisconsin Department of Health Services, Client Rights Office, P.O. Box 7851, Madison, WI 53707-7851

CLIENT RESPONSIBILITIES

As a client, you have the responsibility:

1. To provide complete and accurate information about illness, hospitalization, medications, and other matters pertinent to your treatment plan.
2. To provide and update contact information including your address, phone number, and emergency contact.
3. To provide accurate insurance information and to update when changes occur.
4. To inform the organization when you will not be able to keep your appointment with at least 24 hour notice.
5. To treat the staff with respect.
6. To participate in your treatment plan and adhere to wear and care instructions.
7. To cooperate with staff and ask questions if you do not understand instruction or information given to you.
8. To assist the organization with billing and/or payment issues to help with processing third party payment.
9. To inform the organization of any problems or dissatisfaction with services.