Eschen Prosthetic & Orthotic Laboratories, Inc.

510 East 73rd Street, Suite 201
New York, NY 10021

EPO is a private company which independently provides services to patients referred from a variety of hospitals & physicians. You will be billed separately for all orthotic and prosthetic services provided on an outpatient basis. So that we may have the information necessary to properly bill for these services, please complete this form and sign in the places indicated.

Patient Name: ______________________________________ Sex:__________
(Last) (First) (M) (Sr. or Jr.)

Address: ____________________Apt#: ____ City: ______________ State: _____ Zip:________

Tel# Day: ________________Cell No. ________________Email: ______________________

Date of Birth: ____________ **SS#:** ____-____-______

Referring Physician: ________________ Clinic: __________________

Parent/Guardian: ____________________________ Relationship: __________ DOB: __________
(Last) (First)

Address (if different from Patient): ________________City: ____________ State: _____ Zip: ______

Tel # Day: ______________ Cell No.: ________________ Email: ______________________
(if different from Patient)

Primary Insurance Carrier: ____

Type of Coverage: ____________ Policy#: ________________ Group#: ________________

Secondary Insurance Carrier: ____

Type of Coverage: ____________ Policy#: ________________ Group#: ________________

Worker Compensation/Automobile cases only. Please provide the following information.

Employer: ____Policy#________________

W.C./Auto Carrier Name: ________________________ Carrier Address: ________________

Claim#: __________ Date of Accident: ________ Contact Person: ____________ Phone: ___________

Treatment Consent: By signing below, I hereby consent to having Eschen Prosthetics and Orthotics Laboratories, Inc., its staff and employees, provide P&O services to me/my dependent. I consent to authorize them to take any and all measurements, castings, moldings, photographs, tracings, etc. as necessary to design, fabricate, fit and deliver the prescribed devices.
I further hereby acknowledge receipt of the Notice of Privacy Practices and agree to sign a receipt for any device(s) provided to me upon satisfactory completion and delivery of such device(s).

X____ Date: ________________

Release and Assignment: I, ______________________, authorize the release of any and all medical information necessary to process claims made on my behalf and request that payment of benefits be made directly to Eschen Prosthetics and Orthotics Laboratories, Inc.

Payment Agreement: I, __________________, understand that some policies do not fully cover all charges. I agree that I will assume responsibility for any approved copayment and/or deductible amounts for covered procedures and the full charge for any uncovered procedures.

X____ Date: ________________

Acknowledgement of Receipt of Notice of Privacy Practices

I certify that I have received a copy of Eschen Prosthetic and Orthotic Laboratories Inc., Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of Eschen Prosthetic and Orthotic describes my rights and Eschen Prosthetic and Orthotic Laboratories Inc. duties with respect to my protected health information. The Notice of Privacy Practices is posted in 510 East 73rd Street, Suite 201 – New York, NY 10021.

ESCHEN PROSTHETIC AND ORTHOTIC LABORATORIES INC. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, asking for one at the time of my next appointment.

____
Signature of Patient or Personal Representative

____
Name of Patient or Personal Representative

____
Date

____
Description of Personal Representative's Authority

PRODUCT WARRANTY INFORMATION

The warranty period for custom orthoses is six months for workmanship and materials. Although Eschen cannot be responsible for physiological or anatomical changes in the patient's medical condition, Eschen will attempt to maintain proper fit during this period. Normal adjustments to enhance fit will be made at the discretion of the practitioner at no charge for a period of up to one year. Additional charges will be imposed for additions of components, straps, lifts, etc. prescribed by a physician and for adjustments or repairs that are made as a result of abuse or extraordinary or abnormal wear, as may occur from sporting, vocational or unusual activities. Since custom orthoses are prescribed at the direction of a physician, and specifically fabricated for the anatomy and medical condition of each individual patient, they cannot be returned for credit or refund. Prescribed "off -the- shelf" items cannot be returned for hygienic reasons.

Off-the-shelf (OTS) braces will be warranted as per the manufacturer's warranty. See below for examples:

Post Operative Braces and Walking Boots
90 days - soft goods
180 days - mechanical functionality/components
Functional Braces (OTS Knee)
90 days - soft goods
1 year - mechanical functionality/components
1 year - hinge functionality/components
5 years - against shell breakage
Osteoarthritis Braces
90 days - soft goods
1 year - mechanical functionality/components
3 years - hinge functionality/components

Please communicate any problems or discomfort you are experiencing to your practitioner immediately to allow us to resolve problems as efficiently and quickly as possible.

HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

OUR LEGAL DUTY

We are required by applicable Federal and State law to maintain the privacy of your health information. We also are required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. This notice takes effect April 14, 2003. We reserve the right to change the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and apply the new terms of our Notice to health information that we maintain, including health information we created or received prior to making such changes.

USES AND DISCLOSURES OF HEALTH INFORMATION

The following categories describe different ways that we use and disclose your protected health information.
Treatment: We may use and disclose your health information to physicians or other healthcare providers providing treatment to you.
Payment: We may use and disclose your health information to obtain payment for services we provide to you.

HIPAA NOTICE OF PRIVACY PRACTICES (cont'd)

National Security: We may release protected health information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law. We may disclose to law enforcement officials having lawful custody of a patient the protected health information of the patient under certain circumstances mandated by law.

Workers' Compensation: We may release protected health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness. Release of such information is controlled by State and/or Federal law.
Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose protected health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

PATIENT RIGHTS

Access: You have the right to inspect and copy health information that may be used to make decisions about your care. This includes medical and billing records. To inspect and/or copy your health information you must submit your request in writing. You will be charged $.25 per page for copies, plus our postage costs.
Right to Amend: You have the right to request that we amend your health information. Your request must be in writing and you must provide a reason that supports your amendment request. We may deny your request if you ask us to amend information that:

- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the health information kept by us ;
- in our judgment is accurate and complete as it appears or as it was at the time it was originally captured and recorded.

Disclosure Accounting: You have the right to receive a list of disclosures we have made of your health information for the last 6 years. If you request this accounting more than once in a 12 month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.
Restriction: You have the right to request a restriction or limitation on the protected health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the protected health information we disclose about you to someone, such as a family member or friend, who is involved in your care and/or the payment for your care. You must request any such restriction in writing, however, prior to the date we make or have made such disclosures. Although we are not required to agree to such a request if we believe it is not in your best interest to do so, except in case of emergency, we will abide by any requested restriction to which we have agreed.
Complaints: If you believe your privacy rights have been violated, you may file a complaint with our office or with the U.S. Department of Health and Human Services. To file a complaint with our office, please submit it in writing to the address as follows:

PRIVACY OFFICER - ESCHEN P&O Labs, Inc.
510 East 73rd Street, Suite 201A
New York, NY 10021
Phone: (212) 606-1262

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.