Network Insurers

We currently have contracts with the following insurance companies:

AARP United HealthCare (Medicare Product)
AARP-Medicare Complete / UHC-Secure Horizons (Medicare Product)
AETNA HMO, PPO, ASO and Advantra
BCBS Anthem – MO & IL: HMO, PPO, Federal, Medicare Product
Cigna—All products except EPO
Essence
First Health Network
Healthlink – HMO, PPO, Open Access
Home State Health Plans
Humana
Medicaid – MO (MO = MoHealthNet)
Medicare – MO & IL (MO = Noridian Medicare)(IL = National Government Services)
PHCS
SSM/WellFirst Health
Tricare North Region / Healthnet Federal Services
Tricare for Life (secondary)
UHC – United HealthCare, Evercare, Community Plan, Dual Complete, Shared Services
VAMC – Veterans Administration Medical Center
Work Comp

We are contracted with most of the major medical management services for workers' compensation cases.

MSC	Corvel	United Medical Equipment
PMSI	PMI	HealthLink Work Comp

Resource O&P
Pedorthics, Orthotics and Prosthetics

Patient Information

Date: _____/_____/_____

Patient Demographics (PLEASE PRINT)

Name (Last, First): ________________________________ Birth Date: ____/____/____

Social Security#: ________________________________ Age: ________________________

Home Address: ________________________________ Home Phone#: _______________

City, State, Zip: ________________________________ Cell Phone#: _________________

Marital Status: Married Single Other Sex: Female Male Work Phone#: ________________

Guardian: ________________________________ Relationship: _________________

Referring Physician: ___________________________ Phone#: _____________________

Primary Care Physician: ________________________ Phone#: _____________________

Insurance Information (Fill Out ALL Information Completely)

Primary Insurance

Insurance Plan Name: __________________________ ID#: _________________________

Subscriber's Name (Last, First): _____________________ Group #: _____________________

Subscriber's Employer: _________________________ Subscriber's Birth Date: ___/___/___

Secondary Insurance

Insurance Plan Name: __________________________ ID#: _________________________

Subscriber's Name (Last, First): _____________________ Group #: _____________________

Subscriber's Employer: _________________________ Subscriber's Birth Date: ___/___/___

Other Insurance:________________________________

Health Information

Please circle if you have a history of any of the following:

Diabetes Congenital Anomalies Circulatory Problems Sensory Deficits

If you have diabetes, who manages your condition?

Practitioner: ______________________________ Phone#: ___________________________

Have you received orthotics/prosthetics or orthopedic footwear in the last 12 months?

Yes No If yes, what did you receive? ____

Terms of Agreement

- I understand that by signing this agreement, I authorize provision of products of services to me by Resource O&P. I also understand that I am under the control of my attending physician and that Resource O&P is not liable for any act or omission when following the instructions of said physician.
- I have received, read and understand my patient/client Bill of Rights and patient/client responsibilities.

Fees & Payments

- I authorize direct payment to Resource O&P of any insurance benefits otherwise payable to me for Resource O&P provided products or services. I also authorize my insurance company (ies) to furnish to an agent of Resource O&P any and all information pertaining to my insurance benefits and status of claims submitted by benefit determination.
- While there may be insurance coverage for those services or products provided by Resource O&P to me, I recognize that all services may not be covered or that reimbursement may be less than 100 percent of charges billed in accordance with my policy coverage. Therefore, I acknowledge financial responsibility for any balance owing on my account and agree to pay within 30 days of invoice date.
- I understand that supplies dispensed to me may not be returned to Resource O&P for credit or refund.
- Monthly finance charges 1.5% will be assessed on past due balances. Annual percentage of 18% per annum.
- I understand that I am liable for any and all fees incurred in the process of collecting of any debt owing Resource O&P by me.
- Checks returned for insufficient funds are subject to a $30 charge by Resource O&P. This charge is over and above any charge issued by your bank.
- We accept most major credit cards and there will be a 3% service fee.

Use of Medical Information

- I hereby authorize any holder of medical information about me to release to Resource O&P any records pertaining to my medical history, service rendered, or treatment
- I consent to the release of my Resource O&P records to be reviewed by authorized representatives of Medicare/Medicaid, Medicare intermediary, and/or my private insurance company (ies) for use in determining my orthotic/prosthetic benefits. Specifically, I authorize and request Resource O&P to allow the individual/agency requesting to review my clinical records to examine my personal and medical records.
- I understand that I have the legal right to refuse the release of my personal and medical records now held by Resource O&P and that I am waiving this legal right by signing this consent This consent shall be valid for whatever period of time is reasonably necessary for the individual/agency requesting to review my clinical records to fulfill the above described purpose(s), or until I revoke this consent in writing, such a revocation of the is consent shall have a prospective effect only.

Signature: ____ Date: ____/____/____

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Division of Wrymark, Inc.
11833 Westline Industrial Drive
St. Louis, MO 63146-3312
314-997-1990 Fax 314-997-0106

Please initial/sign the following:

I acknowledge receipt of/or have been offered a copy of the following information:

________Copy Financial Policy
________HIPAA (Notice of Patient Privacy Right)
________Medicare Supplier Standards

Communication Authorization

I authorize Resource O&P to leave messages on my home phone/cell phone or contact me by email at

____.

I permit Resource O&P to collect my health care information from my physicians to receive payment for their services for my device.

Delivery Acknowledgement

- **This is to certify that I have received my device as prescribed by my physician and I am satisfied with the device.**
- **I have received instructions on the function, care, use maintenance and precautions of my device.**
- **I have been scheduled for a follow-up appointment or informed when to call for a follow-up appointment as appropriate to my device.**
- **I have been informed of the warranty policy.**
- **I have been informed if I have any issues or discomfort with my device to call the company.**

Payment Authorization

- **I assign the right and responsibility to Resource O&P to bill my insurance carrier on my behalf and accept payment for my device.**
- **I authorize my insurance carrier to make payment to Resource O&P.**
- **I accept responsibility for my coinsurance and my deductible on this device.**

Patient Signature/Representative______________________________ **Date**__________________

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MEDICARE SUPPLIER STANDARDS

Medicare regulations have defined standards that a supplier must meet to receive and maintain a supplier number. The supplier must certify in its application for billing privileges that it meets and will continue to meet the standards. The supplier standards can be found in 42 CFR Section 424.57(c).

The following is an abbreviated version of the supplier standards:

1. A supplier must be in compliance with all applicable Federal and State licensure and regulatory requirements and cannot contract with an individual or entity to provide licensed services.
2. A supplier must provide complete and accurate information on the DMEPOS supplier application. Any changes to this information must be reported to the National Supplier Clearinghouse within 30 days.
3. An authorized individual (one whose signature is binding) must sign the application for billing privileges.
4. A supplier must fill orders from its own inventory, or must contract with other companies for the purchase of items necessary to fill the order. A supplier may not contract with any entity that is currently excluded from the Medicare program, any State health care programs, or from any other Federal procurement or non-procurement programs.
5. A supplier must advise beneficiaries that they may rent or purchase inexpensive or routinely purchased durable medical equipment, and of the purchase option for capped rental equipment.
6. A supplier must notify beneficiaries of warranty coverage and honor all warranties under applicable State law, and repair or replace free of charge Medicare covered items that are under warranty.
7. A supplier must maintain a physical facility on an appropriate site. This standard requires that the location is accessible to the public and staffed during posted hours of business. The location must be at least 200 square feet and contain space for storing records.
8. A supplier must permit CMS, or its agents to conduct on-site inspections to ascertain the supplier's compliance with these standards. The supplier location must be accessible to beneficiaries during reasonable business hours, and must maintain a visible sign and posted hours of operation.
9. A supplier must maintain a primary business telephone listed under the name of the business in a local directory or a toll free number available through directory assistance. The exclusive use of a beeper, answering machine, answering service or cell phone during posted business hours is prohibited.
10. A supplier must have comprehensive liability insurance in the amount of at least $300,000 that covers both the supplier's place of business and all customers and employees of the supplier. If the supplier manufactures its own items, this insurance must also cover product liability and completed operations.
11. A supplier must agree not to initiate telephone contact with beneficiaries, with a few exceptions allowed. This standard prohibits suppliers from contacting a Medicare beneficiary based on a physician's oral order unless an exception applies.
12. A supplier is responsible for delivery and must instruct beneficiaries on use of Medicare covered items, and maintain proof of delivery.
13. A supplier must answer questions and respond to complaints of beneficiaries, and maintain documentation of such contacts.
14. A supplier must maintain and replace at no charge or repair directly, or through a service contract with another company, Medicare-covered items it has rented to beneficiaries.
15. A supplier must accept returns of substandard (less than full quality for the particular item) or unsuitable items (inappropriate for the beneficiary at the time it was fitted and rented or sold) from beneficiaries.
16. A supplier must disclose these supplier standards to each beneficiary to whom it supplies a Medicare-covered item.
17. A supplier must disclose to the government any person having ownership, financial, or control interest in the supplier.
18. A supplier must not convey or reassign a supplier number; i.e., the supplier may not sell or allow another entity to use its Medicare billing number.
19. A supplier must have a complaint resolution protocol established to address beneficiary complaints that relate to these standards. A record of these complaints must be maintained at the physical facility.
20. Complaint records must include: the name, address, telephone number and health insurance claim number of the beneficiary, a summary of the complaint, and any actions taken to resolve it.
21. A supplier must agree to furnish CMS any information required by the Medicare statute and implementing regulations.
22. All suppliers must be accredited by a CMS-approved accreditation organization in order to receive and retain a supplier billing number. The accreditation must indicate the specific products and services, for which the supplier is accredited in order for the supplier to receive payment of those specific products and services (except for certain exempt pharmaceuticals).
23. All suppliers must notify their accreditation organization when a new DMEPOS location is opened.
24. All supplier locations, whether owned or subcontracted, must meet the DMEPOS quality standards and be separately accredited in order to bill Medicare.
25. All suppliers must disclose upon enrollment all products and services, including the addition of new product lines for which they are seeking accreditation.
26. Must meet the surety bond requirements specified in 42 C.F.R. 424.57(c).
27. A supplier must obtain oxygen from a state- licensed oxygen supplier.
28. A supplier must maintain ordering and referring documentation consistent with provisions found in 42 C.F.R. 424.516(f).
29. DMEPOS suppliers are prohibited from sharing a practice location with certain other Medicare providers and suppliers.
30. DMEPOS suppliers must remain open to the public for a minimum of 30 hours per week with certain exceptions.

________________________ PATIENT SIGNATURE

________________________ DATE

Acknowledgment of Receipt of Notice of Privacy Practices

I certify that I have received a copy of Resource O&P Notice of Privacy of Practices. The Notice of Privacy of 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 Resource O&P health care operations. The Notice of Privacy of Practices also describes my rights and Resource O&P duties with respect to my protected health information. The Notice of Privacy Practices is posted at the front desk.

Resource O&P 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 or asking for one at the time of my next appointment.

____

Signature of Patient or Personal Representative

____

Name of Patient or Personal Representative

____

Description of Personal Representative's Authority

____

Date

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MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting us to be a part of your medical team. When you schedule an appointment with us, we set aside up to one hour (depending on the type of appointment) to provide you with the highest quality of care. Should you need to cancel or reschedule an appointment **please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment**. This gives us time to accommodate other patients who may be waiting for an urgent appointment opening. Please see our Appointment Cancellation/No Show Policy below.

- Any established patient who **fails to show or cancels/reschedules an appointment and has not contacted our office with at least 24 hour notice** will be considered a No Show and charged a $45.00 fee.
- Any established patient who fails to no show or cancels/reschedules an appointment without 24 hour notice **a second time** will be charged $50.00.
- Any **new patient who fails to show for their Initial visit will be assessed a $50.00 fee**.
- The fee is charged to the patient, not the Insurance company, and the patient will not be permitted to reschedule or make additional appointment until this fee has been paid.
- As a courtesy, we make reminder calls for appointments 24 hours in advance. If you do not receive a reminder call or message, **the above Policy will still remain in effect**.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your schedule appointment. If you should experience extenuating circumstances, please contact our office. You may contact Resource O&P during regular business hours at 314-997-1990 or after business hours at same number and leave a message on extension 225. Messages left on the office voicemail are acceptable.

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its term.

______________________________	____________________	__________
Signature (Patient, Parent/Legal Guardian)	Print Name	Date