Ideal HealthCare
A MOBILITY CLINIC COMPANY

PHYSICIAN ORDER AND PRESCRIPTION

Patient Name: _____ Date: _____

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

Home Phone: _____ Cell Phone: _____ Social Security: _____

Insurance Co. _____ ID: _____ Date of Birth: _____ Male: ____ Female: _____

Waist Circumference (around belly button): _____ Shoe Size: _____ Knee Circumference: _____

WRIST/HAND:

□ Carpel Tunnel Syndrome (354.0)
□ Sprains & strains of Wrist and Hand (842.00)
□ Other: _____
□ Other: _____

NECK/SPINE:

□ Lumbosacral Radiculitis (724.4)
□ Spinal Stenosis (724.02)
□ Muscle Weakness (723.1)
□ Cervicalgia (756.12)
Lumbar Disc Displacement (722.10)
□ Lumbar/Lumbosacral Disc Degeneration (722.52)
□ Lumbosacral Plexus Lesion (353.0)
□ Lumbar Strains/Sprain (847.2)
□ Osteoporosis (733.0)
□ Other: _____

KNEE/LEG:

□ Rheumatoid Arthritis (714.0-714.4)
□ Osteoarthritis (715.16) (715.26) (715.36) (715.96)
□ Knee Instability (718.86)
□ Other: _____
□ Sprain of the Lateral Collateral Ligament (844.0)
□ Sprain of the Medial Collateral Ligament (844.1)
□Sprain of the Cruciate Ligament of the Knee (844.2)
□ Other: _____

For Spine bracing please check the applicable option(s):

□ To facilitate healing following a surgical procedure in the spine or related soft tissue
□ To facilitate healing following an injury to the spine or related soft tissue
□ To reduce pain by restricting mobility of the trunk
□ To otherwise support weak spinal muscles and/or a deformed spine

PLEASE DISPENSE THE FOLLOWING PRODUCT(S)

□ **L0631 Prolign Pro® Lumbar Orthosis-** Sagittal control with Rigid Anterior Insert to provide support to the Intra-Abdominal and Viscera Region helping to unload the spine under gravitational load. Posterior plastic insert to Maintain neutral sagittal alignment. Extends from sacrococcygeal junction to T9 vertebra.					
□ **L2114 Cam Walker-** semi-rigid, prefabricated, includes fitting and adjustment	□ LT	□ RT	□ **L1971 Ankle Foot Orthosis-** plastic or other material with ankle joint prefabricated w/ fittings	□ LT	□ RT
□ **L3908 Univ. Wrist Splint-** rigid w/o joint(s)	□ LT	□ RT	□ **L3807 Univ. Thumb Spica-** w/o joint(s)	□ LT	□ RT
□ **L0174 Universal XTW Cervical Collar-** Cervical Collar, Semi-Rigid w/ Thermoplastic Foam. Two Pieces w/ Thoracic Ext.					
□ **L1832 Warrior® Pro Knee Brace-** Knee Orthosis, Adjustable Knee Joints (Unicentric or Polycentric), Positional Orthosis, Rigid, Support, For Mild to Moderate ACL, PCL, MCL, LCL, or Combined Ligament instabilities				□ LT	□ RT

□ **TENS UNIT 3900**	□ **NEBULIZER E0570**	□ **ANKLE AIRCAST L4350**	□ **CANE E0100**	□ **QUAD-CANE E0105**

Rx: Estimated Length of Need (# of months) _____ 1-99 (99=Lifetime)

This patient is being treated under a comprehensive plan of care for orthopedic pain management. I undersigned certify that the prescribed orthosis is medically necessary for the patient's overall treatment of:

Physician Signature: _____ Date: _____ NPI: _____

Print Physician Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____

DMEPOS Product(s) Dispensing and Setup Form

Patient's Name:	Patient/ Delivery Address:
DOB:	
Date:	Shipping Service Tracking Numbers
Time:	
DMEPOS Product Name(s) and Quantities:	

Manufacturer:	Serial number:	Lot Number/Expiration Date:

DMEPOS Product(s) Dispensing Occurred at:

□ Office □ Patient/Caregiver Home □ Residential Care Setting

DMEPOS Product(s) Setup Required (check all that apply):

□ Sizing □ Programming □ Battery Insertion
□ Assembly □Other (specify): _____

Patient Assessment, Training, Education Provided *(check all that apply):*

□ Patient has been assessed for the appropriateness of the DMEPOS
□ Patient trained on the proper use, care, maintenance and storage of Product
□ Patient aware of all available accessories
□ Home Assessment completed for Oxygen/Mobility Patients
□ Patient alerted to potential risks or hazards associated with Product, including Infection Control
□ Patient Concerns and Feedback addressed
Product assessed for structural integrity and meets manufacturer guidelines
□ Patient understands the Setup and Prescribing Physician's directions
□ Patient aware of Manufacturer and Office Customer Service options

Documentation Provided *(check all that apply)*:

☐ Manufacturer Documentation

☐ Warranty

☐ Instructions

☐ Patient Satisfaction Survey of DMEPOS Products and/or Services Form

☐ Scope of Services (including normal and after hour contact information)

☐ Receipt of Patient/Beneficiary Charges Deductible and Co-Payment Amount

☐ Copy of the Advance Beneficiary Notice (ABN) -*if applicable*

Documentation Provided

(*New Patient only)

□ *CMS DMEPOS SUPPLIER STANDARDS (MEDICARE ONLY)

□ *NOTICE OF PRIVACY PRACTICES

PATIENT BILL OF RIGHTS AND RESPONSIBILITIES
To ensure the finest care possible, as a Patient receiving Durable Medical Equipment (DME) and our Office services, you should understand your role, rights and responsibilities involved in your own plan of care.

Patient Rights

- To select those who provide you with DME and Pharmacy services
- To receive the appropriate or prescribed services in a professional manner without discrimination relative to your age, sex, race, religion, ethnic origin, sexual preference or physical or mental handicap.
- To be treated with friendliness, courtesy and respect by each and every individual representing our Office, who provided treatment or services for you and be free from neglect or abuse, be it physical or mental
- To assist in the development and preparation of your plan of care that is designed to satisfy, as best as possible, your current needs, including management of pain
- To be provided with adequate information from which you can give your informed consent for commencement of services, the continuation of services, the transfer of services to another health care provider, or the termination of services
- To express concerns, grievances, or recommend modifications to your DME and Pharmacy services, without fear of discrimination or reprisal
- To request and receive complete and up-to-date information relative to your condition, treatment, alternative treatments, risk of treatment or care plans
- To receive treatment and services within the scope of your plan of care, promptly and professionally, while being fully informed as to our Office's policies, procedures and charges
- To request and receive data regarding treatment, services, or costs thereof, privately and with confidentiality
- To be given information as it relates to the uses and disclosure of your plan of care
- To have your plan of care remain private and confidential, except as required and permitted by law

Patient Responsibilities

- To provide accurate and complete information regarding your past and present medical history
- To agree to a schedule of services and report any cancellation of scheduled appointments and/or treatments
- To participate in the development and updating of a plan of care
- To communicate in the development and updating of a plan of care
- To communicate whether you clearly comprehend the course of treatment and plan of care
- To comply with the plan of care and clinical instructions
- To accept responsibility for your actions, if refusing treatment or not complying with, the prescribed treatment and services
- To respect the rights of Office Personnel
- To notify your Physician and the Office with any potential side effects and or complications

ASSIGNMENT OF BENEFITS (MEDICARE ONLY) (to be completed once per product type annually)

□ Claim billed as assigned

□ Claim billed as non-assigned

- ✓ I assign the right and responsibility to Medical Finance Resources to bill on my behalf, and accept payment for Medicare DMEPOS products and services provided to me, the Beneficiary
- ✓ I understand that I am responsible to pay any deductible amount applied to the claims and the coinsurance, which is 20 percent of the allowable or approved charge for a product or service
- ✓ I permit Medical Finance Resources to release and collect my health information, and other information, as required (and as permitted by the HIPAA Regulations) from my health care providers and Medicare receiving payment from Medicare.
- ✓ I understand that his form will be maintained and made available to Medicare or its representatives

I acknowledge that I have received the DMEPOS product(s), complete instructions on the use, care, maintenance, and full documentation for the DMEPOS Product(s) listed above.

Patient/ caregiver Signature	Date
Individual Responsible for Dispensing/Setup Signature	Date