Mobility Plus — Patient Intake Form

Date:	Order Taken By:

Beneficiary Information

Patient's Name: *(Print Full Name)*	Male ☐ Female ☐	Date of Birth:

Address:	City:	State:	Zip:

Home Phone#	Cell#	Work#

Email Address:	Patient Height:	Patient Weight:

Person filling out paperwork *(Print Full Name) -If Patient is not completing-*	Relationship

Home Phone#	Cell#	Work#

Primary Physician Information

Name:	Telephone#

Insurance Information

Primary Insurance	Policy#
Supplement Insurance	Policy#

BILLING PRACTICES

When we agree to bill supplies or equipment for you on Insurance, first we check to make sure your coverage is active and that you have not had previous similar equipment, like a wheelchair, in the last five years. We take these precautions to reduce billing errors and surprises that might incur unexpected charges for you. However, no check of previous equipment is guaranteed as the verification system for Insurance is not foolproof.

Medicare only pays 80% leaving a 20% copay or supplemental insurance responsibility. It is a problem to determine what your secondary will pay due to so many plans. Copays are the patient's responsibility. We may or may not check for your yearly deductible.

If your claim does not pay from your Insurance(s), we will charge you what was denied for payment. We will send you an invoice stating the date of service and amount owed and include a return envelope for your payment. We want to make sure you understand how we bill on your behalf and will be happy to further explain any process if you have questions. Insurance reimbursement is not guaranteed. Copays and deductibles may be collected upfront.

_____ (Initial) Yes, I accept all above statements. I also understand and accept all billing procedures and practices.

I understand that any item purchased from Mobility Plus, which we accept Assignment, may not be covered by Insurance. ***I accept responsibility for full payment.***

Signature: _____ Date: _____/_____/_____

If the patient is not the one signing:

Representative's Name *(print)*:_____Relation:_____

Mobility Plus

315 S 37th St Muskogee, OK 74401

Consent to the Use and Disclosure of Health Information for Treatment, Payment and Healthcare Operations

I understand that as part of my healthcare, **Mobility Plus** originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatments
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and procedure information to my bill
- a means by which a third-party can verify that services billed were actually provided and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that I have the option of receiving a copy of the Privacy Notification that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided, if I request. I understand that I have the right to object to the use of my health information in the facility directory, I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations and the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

_____ Initial

ASSIGNMENT OF BENEFITS AUTHORIZATION

If other health insurance is indicated on the HCFA-1500 form, or else on other approved claim forms or electronically submitted claims, my signature authorizes the release of information to the insurer or agency shown

I authorize the release of all records required in applying for payment under Title XVIII of the Social Security Act is correct.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize Mobility Plus to review and obtain copies of my medical records and insurance information as they relate to my reimbursement for charges and care coordination. I also hereby authorize Mobility Plus to furnish to my insurance carriers and other care providers (i.e. any required third party review) any medical history proof of services rendered or treatment needs.

_____ Initial

Is the Beneficiary currently in a Home Health situation? ☐ Yes ☐ No

Is the Beneficiary currently in the Hospital? ☐ Yes ☐ No

Is the primary Insurer information that you have provided accurate? ☐ Yes ☐ No

_____ _____

Signature of Patient/Representative **Print Patient Name**

_____ _____

Date **Witness**

Checklist of Paperwork Provided by Mobility Plus

Customer Name: _____ D.O.B. _____/_____/_____

Attestation:

I (Customer Named Above) will/have received all pertinent information, not all items apply to everyone, that apply to my situation required by government regulatory bodies. These informational items may include some or all examples below:

Company Information/Hours of Operation	Emergency Preparedness (home delivery only)
Patient Information	Home Safety (home delivery only)
Assignment Of Benefits/Release of Information	Welcome Packet
Billing Practices/Financial Responsibility	
HIPAA Privacy	
Educational & Instructional Materials	
Rights & Responsibilities	
ABN (where applicable)	

MEDICARE DMEPOS SUPPLIER STANDARDS

The products and/or services provided to you by Mobility Plus are subject to the supplier standards contained in the Federal regulations shown at 42 Code of Federal Regulations Section 424.57(c). These standards concern business professional and operational matters (e.g. honoring warranties and hours of operation). The full text of these standards can be obtained at http://www.ecfr.gov. Upon request we will furnish you a written copy of the standards.

Supply Use/Instruction

To Whom It May Concern:

I have received verbal and written instructions on how to use the durable medical equipment/supplies that I have purchased from Mobility Plus. I understand that Medicare defines the item(s) I have purchased as an inexpensive or routinely purchased item.

Date: _____/_____/_____

Item Purchased:_____

Please Print

Supplemental Question:

Circle Yes or No

1. Has the beneficiary ever received the same or similar supplies/equipment? Yes No

Customer Signature: _____ Date: _____/_____/_____

Mobility Plus

Where the "Plus" is in the Service

315 S 37th St
Muskogee, Oklahoma 74401

Hours of Operation

Showroom Floor & Business Office:
Monday - Friday 8:30am - 5:00pm

Phone: (918) 686-0218 || ***Fax:*** (918) 686-0345

Departments:

Homecare Team Member = #1	Advantage Department = #4
Power Mobility Department = #2	Billing Inquiries = #5
CPAP Supplies & Service = #3	Accounts Payable = #6

PATIENT INFORMATION PACKET

Contents

***YOU MAY USE OUR **AFTER HOURS CALL LINE** FOR *EMERGENCIES.*
CALL (918) 686-0218 AND FOLLOW THE PROMPTS.***

BILL OF PATIENT RIGHTS AND RESPONSIBILITIES

Mobility Plus supports the patient's bill of rights. You have the right to be notified in writing of your rights and obligations before treatment has begun. The patient's family or guardian may exercise the patient's rights when the patient has been judged incompetent, Mobility Plus has an obligation to protect and promote the rights of their patients, including the following rights:

Rights

As the patient/caregiver, you have the RIGHT to:

- Be treated with dignity and respect.
- Confidentiality of patient records and information pertaining to a patient's care.
- Be presented with information at admission in order to participate in and make decisions concerning your plan of care and treatment.
- Be notified in advance of the types of care, frequency of care, and the clinical specialty providing care.
- Be notified in advance of any change in your plan of care and treatment.
- Be provided equipment and service in a timely manner.
- Receive an itemized explanation of charges.
- Be informed of company ownership.
- Express grievance without fear of reprisal or discrimination.
- Receive respect for the treatment of one's property.
- Be informed of potential reimbursement for services under Medicare, Medicaid or other third party insurers based on the patient's condition and insurance eligibility (to the best of the company's knowledge)
- Be notified of potential financial responsibility for products or services not fully reimbursed by Medicare, Medicaid or other third party insurers (to the best of the company's knowledge)
- Be notified within 30 working days of any changes in charges for which you may be liable.
- Be admitted for service only if the company can provide safe, professional care at the scope and level of intensity needed, if Mobility Plus is unable to provide services then we will provide alternative resources.
- Purchase inexpensive or routinely purchased durable medical equipment.
- Have the manufacturer's warranty for equipment purchased from "Mobility Plus" honored.
- Receive essential information in a language or method of communication that you understand.
- Each Patient has a right to have his or her cultural, psychosocial, spiritual, and personal values, beliefs and preferences respected.
- Patients have the right to be free from mental, physical, sexual, and verbal abuse, neglect and exploitation.
- The patient has the right to access, request amendment to, and receive an accounting of disclosures regarding his or her health information as permitted under applicable law.
- The Patient has the right to refuse home equipment and care provided through Mobility Plus

Client Responsibilities:

As the patient/caregiver, you are RESPONSIBLE for;

- Notifying the company of change of address, phone number, or insurance status.
- Notifying the company when service or equipment is no longer needed.
- Notifying the company in a timely manner if extra equipment or services will be needed.
- Participation as in the plan of care/treatment.
- Notify the company of any change in condition, physician orders, or physician.
- Notifying the company of an incident involving equipment.
- Meeting the financial obligations of your health care as promptly as possible.
- Providing accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other maters pertinent to your health.
- Your actions if you do not follow the plan of care/treatment.

Our Rights:

As your supplier of choice we have the right to:

- Terminate services to anyone who knowingly furnishes incorrect information to our company to secure medication or equipment and supplies.
- To refuse services to anyone who enters our company and is verbally abusive, threatening, intoxicated by alcohol, drugs and/or chemical substances and could potentially endanger our staff and patients.

Patient Information:

- **After Hours Services:** The after hours phone number is (918) 686-0218. You may leave a message after normal business hours for all other needs.

- **Complaint Procedure:** You have the right and responsibility to express concerns, dissatisfaction or make complaints about services you do or do not receive without fear of reprisal, discrimination or unreasonable interruption of services. The telephone number is (918) 686-0218; when you call ask to speak with the Manager.

- **Mobility Plus has a formal grievance procedure** that ensures that your concerns will be reviewed and an investigation started within 48 hours. Every attempt shall be made to resolve all grievances within 14 days. You will be informed in writing of the resolution of the complaint/grievance. The complaint form is available upon request.

- **The toll-free number for Medicare** to file a complaint/or to speak with customer service is 1-800-MEDICARE or 1-800-633-4227.