My Foot Rx
ORTHOTICS and SPECIALTY SHOEWORK

Welcome

My Foot Rx, LLC was established in 2016.
We provide specialty shoe work and cast and fit custom foot orthotics.
Compassion is our foundation; everlasting foot health is our pursuit.

Monday, Wednesday, Thursday 8:30 am–5 pm • Tuesday 8:30 am–1 pm • Friday by appointment
1706 York St STE #3 Bloomer, WI 54724 • e-mail: myfootrx@yahoo.com
Phone: (715) 568-1500 • After hours (715) 577-9098

Patient Information Packet Contents

Rights and Responsibilities

As our customer, you are hereby provided this 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. We fulfill our obligation to protect and promote the rights of our patients, including the following:

Customer 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 and 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.
- 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 we are unable to provide services then we will provide alternative resources.

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- Purchase inexpensive or routinely purchased durable medical equipment.
- Expect that we will honor the manufacturer's warranty for equipment purchased from us.
- 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.
- To be free from mental, physical, sexual, and verbal abuse, neglect and exploitation.
- Access, request an amendment to, and receive an accounting of disclosures regarding your health information as permitted under applicable law.

CUSTOMER 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.
- Participating as in the plan of care/treatment.
- Notifying 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 matters pertinent to your health.
- Your actions if you do not follow the plan of care/treatment.

OUR RIGHTS

As your provider of choice, we have the right to:

- Terminate services to anyone who knowingly furnishes incorrect information to our company to secure durable medical equipment.
- To refuse services to anyone who during direct care is threatening, intoxicated by alcohol, drugs and/or chemical substances, and could potentially endanger our staff and patients.

COMPLAINT PROCEDURE

My Foot Rx LLC provides a process for clients to lodge an oral, written, or telephone complaint about the products and services provided. My Foot Rx LLC has a complaint resolution system for identifying, responding to, and resolving complaints in a timely manner. All written, oral, and Name of client or caregiver voicing the complaint

A summary of the complaint, including:

- Date received
- Name of the person receiving the complaint
- A summary of actions taken to resolve the complaint
- If an investigation is not conducted, the name of the person who made that decision, along with the reason for not investigating
- Signature of supervisor

All employees are trained in how to handle complaints. Copies of all complaints and investigations are kept on-file for at least three years. All complaints are summarized and presented to Executive Management quarterly.

If you have a complaint, please contact us at (715) 577-9098. Additionally, you may contact Centers for Medicare and Medicaid Services (CMS) at 1(800) MEDICARE, if needed. You may also contact our accreditation provider if needed. Our accreditation provider is HQAA and can be reached at (319) 236-6909.

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EMERGENCY PREPAREDNESS

My Foot Rx LLC has a comprehensive emergency preparedness plan in case a disaster occurs. Disasters may include fire to our facility, chemical spills in the community, hurricanes, tornadoes and community evacuations. Our primary goal is to continue to service your health care needs. It is your responsibility to contact us regarding any supplies you may require when there is a threat of disaster or inclement weather so that you have enough supplies to sustain a disaster occurs, follow instructions from the civil authorities in your area. We will utilize every resource available to continue to service you. However, there may be circumstances where we cannot meet your needs due to the scope of the disaster. In that case, you must utilize the resources of your local rescue or medical facility. We will work closely with authorities to ensure your safety.

Equipment Warranty Information

Shoes can be returned if unworn for exchange for 30 days. Defective items can be returned up to 6 months for repair or replacement. Custom items are not returnable but will be adjusted for six months from date of delivery. Any items that are abused or worn past adjustable conditions will need to be replaced at patient's expense.

Patient Privacy (HIPAA) Information

ATTENTION: this notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

My Foot Rx LLC is committed to preserving the privacy of your personal health information. In fact, we are required by law to protect the privacy of your medical information and to provide you with this notice describing the following how your medical information is used and disclosed for your treatment, to obtain payment for treatment, administrative purposes and to evaluate the quality of care that you receive. This page remains with the patient.

USES AND DISCLOSURES

We use and disclose elements of your Protected Health Information (PHI) in the following ways:

- Treatment: including, but not limited to, inpatient, outpatient or psychiatric care.
- To your treating physician(s). Payment: including, but not limited to, asking you about your health care plan(s), or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts, either ourselves or through a collection agency or attorney.
- Health care operations: including, but not limited to, financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.
- Disclosures when release is authorized by law: including, but not limited to, judicial settings and to health oversight regulatory agencies, law enforcement and correctional institutions.
- Uses or disclosures for specialized government functions: including, but not limited to, the protection of the President or high-ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign services.
- In emergency situations or to avert serious health / safety situations.
- If you are a member of the armed forces, we may release medical information about you and your dependents as requested by military command authorities.
- Disclosures of de-identified information.
- Disclosures relating to worker's compensation claims.
- To medical examiners, coroners or funeral directors to aid in identifying you or to help them in performing their duties.
- To organizations that handle organ and tissue donations.
- To public health organizations or federal organizations in the event of a communicable disease or to report a defective device or untoward event to a biological product (food or medication).
- Disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information.

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We may be required or permitted by certain laws to use and disclose your medical information for other purposes without your consent or authorization. We will notify you by e-mail or US Mail of any breaches of your PHI.

You have the following rights concerning your protected health information (PHI):

- **Restrictions:** To request restricted access to all or part of your PHI. To do this, contact the organization's HIPAA Privacy and Security Officer. We are not required to grant your request and you do not have the right to restrict disclosures required by law. If we do agree, we must honor the restrictions you request.
- **Confidential Communications:** To receive correspondence of confidential information by alternate means or location such as phoning you at work rather than at home or mailing your health information to a different address. To do this, contact the organization's HIPAA Privacy and Security Officer. We will take reasonable actions to accommodate your request.
- **Access:** To inspect or receive copies of your PHI. To do this, contact the organization's HIPAA Privacy and Security Officer. In certain circumstances you may not have the right to access your records if the organization reasonably believes (or has reason to believe) that such access would cause harm. Examples include, but are not limited to, certain psychotherapy notes, information compiled in reasonable anticipation of or for use in civil, criminal or administrative actions or proceedings, or information obtained from someone other than a health care provider under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information.
- **Amendments/Corrections:** To request changes be made to your PHI. To do this, contact the organization's HIPAA Privacy and Security Officer. We are not required to grant your request if we did not create the record or the record is accurate and complete. If we deny your request for amendment / correction, we will notify you why, how you can attach a statement of disagreement to your records (which we may rebut), and how you can complain. If we agree to the request, we will make the correction within 60 days and will send the corrected information to persons we know who got the wrong information, and others you specify.
- **Accounting:** To receive an accounting of the disclosures by us of your PHI. To do this, contact the organization's HIPAA Privacy and Security Officer. By law, the list will not include disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law, we can have one 30-day extension of time if we notify you of the extension in writing. We are not required to give you a list of disclosures that occurred before April 14, 2003.

This Notice: To get updates or reissue of this notice, at your request. This page remains with the patient.

Complaints: To complain to us or the U.S. Department of Health & Human Services if you feel your privacy rights have been violated. To register a complaint with us, contact: Owner, Bob Mc Roberts Jr. The law forbids us from taking retaliatory action against you if you complain.

Our Duties: law requires Us to maintain the privacy of your protected health information (PHI). We must abide by the terms of this notice or any update of this notice.

As a patient of My Foot Rx LLC you have important rights relating to inspecting and copying your medical information that we maintain, amending, or correcting the information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

ASSIGNMENT OF BENEFITS (AOB)

I request that payment of authorized Medicare benefits be made to me or on my behalf to My Foot Rx LLC for durable medical equipment and supplies ordered by my physician. I authorize any holder of medical information about me to release to the Center for Medicare Medicaid Services and its agency any information needed to determine these benefits or the benefits payable for related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If 'other insurance' is indicated in item 9 of the CMS-1500 claim form, or elsewhere on the approved claim form or electronically submitted claims, my signature authorizes releasing the information to the insurer or agency listed. In Medicare assigned cases, the supplier agrees to accept the charge of determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered items. Coinsurance and the deductible are based upon the charge determination to the Medicare carrier.

PROVIDING CORRECT INFORMATION AND INFORMATION RELEASE

I certify that the information I furnish is true and correct. I know it is a crime to fill out this form with facts that I know are false or to leave out facts that are important. I hereby authorize My Foot Rx LLC to submit a claim to my insurance carrier or its intermediaries for all covered prescriptions or durable medical equipment and authorize and direct my insurance carrier or its intermediaries to issue payment directly to My Foot Rx LLC. I hereby authorize My Foot Rx LLC to furnish complete information requested by my insurance carrier or its intermediaries regarding services rendered. I further agree that I am responsible for paying my co-pays or balances which remain after insurance payments have been made, including any cost of collection or legal fee incurred to collect these balances.

Patient Signature or Signature of Caregiver	If Caregiver, Relationship to Patient
Witness Signature	Date

This form kept in Patient Record and a copy to the patient.

FINANCIAL POLICY

Thank you for choosing My Foot Rx LLC as your health care provider. We are committed to building a successful practitioner-patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is part of that relationship. Please ask if you have any questions about our fees, our policies or your responsibilities.

CO-PAYMENT OPTIONS

Co-Payment is due at the time of service. Your insurance company requires that we collect all co-pays at the time of check-in. We accept cash, check, credit and debit cards. The amount of your co-pay may be listed on the front of your insurance card. If not listed, please contact your insurance provider. Waiver of co-pays may constitute fraud under State and Federal law.

SELF-PAY ACCOUNTS

Self-pay accounts are patients without insurance coverage, patients covered by insurance plans in which the clinic does not participate or patients without an insurance card on file with us. Self-pay accounts will be discounted 5% if requested. Payment will be collected in full at the time of delivery. The balance of your account, including all ancillary services (lab, imaging, etc), will be billed to you following your visit. We are willing to work with you on a payment arrangement for the balance of your account if necessary. It is never our intention to cause financial hardship on our patients, only to provide them with the best care possible with the least amount of stress.

INSURANCE

You will need to present your insurance card at each visit. It is your responsibility to supply us with all necessary insurance information at the time of your appointment. Please contact your insurance company or employer if you have questions about covered services.
Insurance is a contract between you and your insurance company(s). In order to properly bill your insurance company(s), we require that you disclose all insurance information including primary, secondary and any other relevant insurances. We participate in most major insurance plans; however, it is your responsibility to make sure the physician you are seeing is listed with your insurance plan as a participating provider. The insurance company will make final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of charges not covered by insurance. If we are out of network for your insurance company and your insurance company pays you directly, you are responsible for payment and agree to forward payment to us.

PATIENT RESPONSIBILITY

It is your responsibility to understand your benefits and coverage and to obtain proper certification when needed. It is also your responsibility to pay any deductible, co-insurance or any other balance not paid by insurance.

DENIED CLAIMS

Our office will provide all necessary medical information to your insurance carrier to properly process your claim. In the event your claim is denied for any reason, the balance becomes your responsibility and payment is expected at that time.

NO SHOW AND CANCELLATION POLICY

We require 24 hour notice if you are unable to keep a previously scheduled appointment. In the event you do not provide 24 hour notice or do not show up for your appointment, we reserve the right to charge a $25 fee to your account.

RETURNED CHECKS

Any account where a check is returned by our bank with NSF (non-sufficient funds) designation will be charged a $50 NSF fee. This fee, as well as the account balance, is due upon receipt. We reserve the right to only accept payment in the future on your account with cash, credit or debit cards.

PAYMENT PLAN OPTIONS

Patients who have outstanding balances as the result of Deductibles, Co-Insurance or who are self-insured can work with our staff to set up a payment plan. We expect that 50% of your balance is paid at delivery with two equal payments each monthly thereafter. My Foot Rx LLC will not waive, fail to collect, or discount co-payments, co-insurance, deductibles or other patient financial responsibility in accordance with State and Federal law, as well as participating agreements with payers. Additional options may be available – income guidelines apply.

30 MEDICARE DMEPOS SUPPLIER STANDARDS

Note: This is an abbreviated version of the supplier standards every Medicare DMEPOS supplier must meet to obtain and retain their billing privileges. These standards, in their entirety, are listed in 42 C.F.R. 424.57(c).

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). Implementation Date - October 1, 2009
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). Implementation date- May 4, 2009
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.

This page remains with the patient
Version R1.0a

Checklist of Paperwork Provided

I have received the following information:

- Hours of Operation and How to Contact Us
- Welcome
- Rights and Responsibilities
- Complaint Procedure / Emergency Preparedness
- Patient Privacy Notification
- Assignment of Benefits
- Equipment Warranty Information
- Equipment/Supplies Provided

Educational and instructional materials provided with each item such as a user manual or the educational materials provided by the manufacturer

For Medicare Customers When Applicable:

- ABN (only provided when indicated)

For All Medicare Customers:

- 30 CMS Supplier Standards

I understand that I must contact My Foot Rx LLC of any changes in my condition or if I am hospitalized
I certify that I have received all of the equipment and supplies listed on the delivery receipt in excellent condition. I have been properly instructed on how to use and properly take care of the equipment and supplies. I also understand that in the event that payment of my co-insurance or deductible amounts are not made by my insurance carrier(s), I will be responsible for reimbursing to My Foot Rx LLC any balance owed up to the allowed amount.

I authorize any employee of My Foot Rx LLC to contact me by telephone regarding the equipment and supplies I have received, additional items or supplies that I may need and to discuss any billing and/or accounts receivable information.

Patient Signature or Signature of Caregiver	If Caregiver, Relationship to Patient
Witness Signature	Date