Patient Information

ORTHOPAEDIC ASSOCIATES, LLP

❑ Dr. Gregory Harvey ❑ Dr. Vivek Kushwaha ❑ Dr. Alan Rechter ❑ Dr. Navin Subramanian ❑ Dr. David Lin ❑ Dr. Amy Riedel ❑ Dr. Justin Chronister

PATIENT NAME (First Name, Middle Initial, Last Name)	PATIENT ID (Office Use Only)	Office ( ) -	Home ( ) -	THIRD PHONE (MOBILE) ( ) -
ADDRESS	DATE OF BIRTH	SOCIAL SECURITY NUMBER	SEX (M OR F) ❑ M ❑ F	MARITAL STATUS ❑ MARRIED ❑ SINGLE ❑ OTHER
CITY, STATE, ZIP	AGE	EMERGENCY CONTACT PERSON	RELATIONSHIP TO PATIENT	CONTACT PHONE
EMPLOYER		OCCUPATION	PATIENT EMAIL ADDRESS	
REFERRING DOCTOR NAME AND ADDRESS				
PRIMARY CARE DOCTOR NAME AND ADDRESS				
RACE		ETHNICITY		
PHARMACY NAME		ZIP CODE	PHARMACY PHONE NUMBER	
NAME OF AUTHORIZED PARTIES THAT MAY DISCUSS MEDICAL CARE			CONTACT NUMBER	

Is it okay to leave test results on voice mail? ❑ YES ❑ NO

Responsible Party

RESPONSIBLE PARTY NAME (First Name, Middle Initial, Last Name)	Office ( ) -	Home ( ) -	THIRD PHONE (MOBILE) ( ) -
ADDRESS		DATE OF BIRTH	SOCIAL SECURITY NUMBER
CITY, STATE, ZIP		SEX (M OR F) ❑ M ❑ F	PATIENT'S RELATION TO RESP
EMPLOYER		OCCUPATION	RESP PARTY ID (Office Use Only)

Primary Insurance

WHO IS THE PRIMARY INSURED PARTY (CHECK ONE):
❑ Patient (same as above) ❑ Responsible Party (same as above) ❑ Other (complete below)

INSURANCE COMPANY NAME	CO-PAY AMOUNT	INSURED'S NAME (First Name, Middle Initial, Last Name)		
INSURANCE COMPANY ADDRESS		INSURED'S ADDRESS, CITY, STATE, ZIP		
INSURANCE COMPANY CITY, STATE, ZIP		INSURED'S DATE OF BIRTH		
INSURANCE COMPANY PHONE NUMBERS		INSURED'S SOCIAL SECURITY NO.	INSURED'S SEX (M OR F) ❑ M ❑ F	PATIENT'S RELATION TO INSURED
INSURED'S POLICY NUMBER	INSURED'S GROUP #	INSURED'S EMPLOYER		INSURED'S OCCUPATION

Secondary Insurance

WHO IS THE SECONDARY INSURED PARTY (CHECK ONE):
❑ Patient (same as above) ❑ Responsible Party (same as above) ❑ Other (complete below)

INSURANCE COMPANY NAME	CO-PAY AMOUNT	INSURED'S NAME (First Name, Middle Initial, Last Name)		
INSURANCE COMPANY ADDRESS		INSURED'S ADDRESS, CITY, STATE, ZIP		
INSURANCE COMPANY CITY, STATE, ZIP		INSURED'S DATE OF BIRTH		
INSURANCE COMPANY PHONE NUMBERS		INSURED'S SOCIAL SECURITY NO.	INSURED'S SEX (M OR F) ❑ M ❑ F	PATIENT'S RELATION TO INSURED
INSURED'S POLICY NUMBER	INSURED'S GROUP #	INSURED'S EMPLOYER		INSURED'S OCCUPATION

Responsible Party

I / We hereby state that the above information is true and correct to the best of my / our knowledge. I / We authorize ORTHOPAEDIC ASSOCIATES, LLP to release any information acquired in the course of my treatment to my insurance company, employer, Physicians, institutions or third party payors, as required for certain claims filed.

Signature of Patient / Parent / Guardian ____________ Printed Name ____________ Date ____________

I / We authorize direct payment to be made to ORTHOPAEDIC ASSOCIATES, LLP for any and all medical or surgical services rendered. I understand if any services or charges are not covered by my insurance carrier or my eligibility can not be verified. I am responsible for all charges incurred.

Signature of Patient / Parent / Guardian ____________ Printed Name ____________ Date ____________

BP: PULSE: TEMP:

Date:____________

GENERAL INFORMATION

Amy Riedel, DPM
Orthopaedic Associates, L.L.P

Name:____________ Age:______ DOB:__________
Height:______ Weight:______ Shoe Size: _____
Referred by:____________
Are you diabetic? (Please circle) Yes / No
Are you pregnant? (Please circle) Yes / No
Current foot Problem(s): ____________
Was this in an accident? (Please circle) Yes / No If yes, was it on the job accident? (Please circle) Yes / No Date of accident: ______
Have you fallen in the past 12 months? (Please circle) Yes / No
Description of pain: ____________
How long have you had the pain/problem?__________ Where on the foot/ankle? __________
Caused by:__________ Relieved by: __________
Have you had prior treatment for this problem? (Please circle): Yes / No
If yes, what type of treatment and by whom? ____________
Primary Care Doctor:__________ Last Primary Care Doctor Visit: __________
Current medications and doses:____________

Pharmacy Name:__________ Pharmacy Phone:__________

ALLERGIES: None Known / Penicillin / Sulfa Drugs / Aspirin / Codeine / Iodine / Tape / Cortisone / Local Anesthetics / General Anesthesia
Other: ____________

Childhood: (Past Medical History)
- ❑ Unremarkable
- ❑ Rheumatic Fever
- ❑ Polio
- ❑ Cerebral Palsy
- ❑ Bleeding Disorder
- ❑ Musculoskeletal Disorder
- ❑ Diabetes
- ❑ Other ________

Adult: (Past Medical History)
- ❑ Unremarkable
- ❑ High Blood Pressure
- ❑ Chest Pain
- ❑ Shortness of Breath
- ❑ Heart Disease
- ❑ Circulatory Disorders(Phlebitis, Claudication, Bleeding Disorders)
- ❑ Diabetes
- ❑ Gout
- ❑ Arthritis
- ❑ Seizures
- ❑ Lung Problems(Asthma, Bronchitis, Emphysema)
- ❑ Kidney disorders
- ❑ Liver Problems (Hepatitis)
- ❑ HIV
- ❑ Ulcers
- ❑ Thyroid Problems (Please Circle)
  - o Hypothyroid OR Hyperthyroid
- ❑ Stroke
- ❑ Cancer
- ❑ Epilepsy
- ❑ Tuberculosis
- ❑ Chemical Dependency
- ❑ Ankle Swelling
- ❑ Other ________

Family: (Past Medical History)
- ❑ Unremarkable
- ❑ Hypertension
- ❑ Coronary Artery Disease
- ❑ Diabetes
- ❑ Gout
- ❑ Asthma
- ❑ Emphysema
- ❑ Arthritis
- ❑ Glaucoma
- ❑ Stroke
- ❑ Cancer
- ❑ Epilepsy/Convulsions
- ❑ Bleeding Disorders
- ❑ Kidney Disease
- ❑ Thyroid Problems
- ❑ Mental Illness
- ❑ Osteoporosis
- ❑ Birth Defects
- ❑ Tuberculosis
- ❑ Alcoholism
- ❑ Sickle Cell
- ❑ Other ________

PAST SURIGICAL HISTORY

Please list previous surgeries and dates:____________
Complications:____________
Hospitalized: (other than surgeries) ____________

SOCIAL HISTORY

Marital status (Please circle): Single / Married / Widowed / Separated / Divorced
Number of healthy children______ Number of deceased children: ______
Live with (Please circle): Spouse / Family / Nursing Home / Assisted Living / Alone
Number of siblings:______ Patient Occupation: __________
Are you a current/previous smoker? (Please circle) Yes / No # packs per day:____ Smokeless tobacco: Yes / No
If a previous smoker, how long ago did you quit? ________
Do you use any illicit drugs? (Please circle) Yes / No
Exercise includes (Please circle): None / Walking Every Day / Walking Occasionally / Jogging / Aerobic Activity / Treadmill / Weightlifting /
Other:____________
Caffeine (Please circle): Yes / No
Alcohol (Please circle): Yes / No If yes, how often? ________
Diet you eat:____________

BP: PULSE: TEMP:

QUESTIONARIO DE HISTORIA MEDICA

NOMBRE: ______________________________ FECHA: ______________
FECHE DE NACIMIENTO: ______________________ EDAD: ______________
FECHA DE LESION O INICIO DE PROBLEMA: ______________________________
TYPO DE LESION/ENFERMEDAD: ______________________________________
____
____

FUE LESIONADO EN EL TRABAJO? (SI) (NO)
ESTAS TRABAJANDO ACTUALEMNTE/ (SI) (NO)
CUAL ES SU DESCRIPCION/RESPONSIBILIDADES DEL TRABAJO? ______________
____

HISTORIA DE LA LESION/ENFERMEDAD ACTUAL ___________________________
____
____
____
____

HAS TENIDO ALGUN TRATAMIENTO O EXAMENES ANTERIOR? (SI) (NO)
POR FAVOR INDIQUE CUAL EXAMEN O TRATAMIENTO:

____
____
____
____

TIENE PROBLEMAS MEDICOS? (SI) (NO)
POR FAVOR INDIQUE PROBLEMAS MEDICOS:

____
____
____
____

ALGUNA VEZ HA TENIDO CIRUGIA? (SI) (NO)
POR FAVOR INDIQUE QUE TIPO DE CIRUGIA Y CUANDO

____
____
____
____

ESTA TOMANDO ALGUN MEDICAMENTO? (SI) (NO)
POR FAVOR INDIQUE MEDICAMENTO Y DOSIS

____
____
____
____

ERES ALERGICO A ALGUN MEDICAMENTO? (SI) (NO)
POR FAVOR INDIQUE ALERGIA Y TIPO DE REACCION

____
____
____
____

FUMAS?	(SI)	(NO)	CUANTO? ______________
TOMAS ALCOHOL?	(SI)	(NO)	CUANTO? ______________
USA DROGAS ILICITAS?	(SI)	(NO)	

FIRMA DE PACIENTE: ____

ORTHOPAEDIC ASSOCIATES, L.L.P.

ORTHOPAEDIC SURGERY & SPORTS MEDICINE

UNIVERSAL CONDITION, INJURY/ACCIDENT STATEMENT FORM

ALL BOXES MUST BE COMPLETED BEFORE SEEING A PHYSICIAN

PATIENT NAME: ______________________________ *TODAY'S DATE:* ____/____/____

PLEASE COMPLETE THE FOLLOWING STATEMENTS. MOST INSURANCE COMPANIES REQUEST ACCIDENT DETAILS. THIS INFORMATION MAY BE FORWARDED WITH YOUR INSURANCE CLAIM OR PROVIDED TO AN ADJUSTER TO COMPLETE YOUR CLAIM. WE MUST HAVE "*BOX 1: CONDITION OR DATE OF INJURY*" COMPLETED TO FILE YOUR CLAIM.

1. Please check: ☐ CONDITION ☐ INJURY INJURY DATE: ____/____/____ (ON OR ABOUT)

THIS DATE IS REQUIRED FOR INSURANCE FILING

How did the injury or pain occur, what were you doing? (Brief Summary)______________________________

____

2. Did the injury occur during work? ☐ YES ☐ NO
3. Were you clocked in? ☐ YES ☐ NO
4. Were you at lunch? ☐ YES ☐ NO

THIRD PARTY LIABILITY

5. Is there a possible third party liability? ☐ YES ☐ NO

(INJURY OCCURRED SOMEWHERE OTHER THAN HOME OR WORK? SUCH AS AUTO, HOMEOWNER'S PROPERTY, ETC.?)

IF YES, A letter of subrogation should be provided before seeing the physician. Your health insurance may deny the claim if the letter is not obtained.

I certify that this information to be true and accurate. I hereby authorize the release of a copy of this form as may be necessary to obtain reimbursement from any insurance company which may request information regarding my injury or condition and the nature of my treatment. I also understand that I am responsible for responding promptly to my insurance carrier if they request any additional information, and that failure to provide requested information may categorize my treatment as a **"non-covered"** service and may make me personally liable for the charges incurred.

SIGNATURE: ______________________________ *TODAY'S DATE:* ____/____/____

(RESPONSIBLE PARTY)

ORTHOPAEDIC ASSOCIATES, LLP • FINANCIAL POLICY

WELCOME, and thank you for choosing Orthopaedic Associates, L.L.P. for your medical care. We are committed to providing you with quality medical care. Our professional fees have been determined through careful consideration and we believe are reasonable and in line with other area physician charges.

INSURANCE: The patient or their guarantor is responsible for payment for services provided by Orthopaedic Associates, L.L.P. at the time of service. O.A. will file claims directly with your insurance carrier for services verified under your plan. Verification does not guarantee your insurance will pay for services. Payments of co-pays, co-insurance, deductibles or fees for non-covered services are required at the time of service.

HMO/ PPO OR CONTRACTED INSURANCE PLANS: Each time you make an appointment with an O.A. physician, it is your responsibility to make sure that the physician is currently contracted with your plan and that you have obtained the necessary referrals. We will bill your plan and allow 45 days for payment. If the services are not paid the balance will become your responsibility. We will not become involved with disputes between you and your insurance company regarding deductibles, non-covered services, co-insurance, pre-existing conditions, or "reasonable and customary" charges.

IF YOU DON'T HAVE MEDICAL INSURANCE: We request payment at the time of service or satisfactory payment arrangements made prior to service. If you are unable to pay for non-emergent services and do not have insurance, the service or treatment may be delayed until acceptable payment arrangements can be made. If you have any questions about your account balance, please call our billing office at 888-330-1737 between the hours of 8:30 a.m. and 5:00 p.m., Monday through Friday.

MEDICARE: If, you are a Medicare patient, we ask that you pay the Medicare deductible at the time of service only if you have not met the deductible and your 20% Co-insurance. If you have a supplemental policy, then you will only be required to pay the Medicare deductible. As a courtesy to you, Orthopaedic Associates, L.L.P. will file Medicare and any supplemental insurance claims to your insurance carrier(s).

I have read all of the information above and agree that, regardless of my insurance status, I understand I am responsible for the balance on my account for any professional services rendered.

Patient Signature________________________________ Date_______________

INSURANCE ASSIGNMENT & AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize ORTHOPAEDIC ASSOCIATES, L.L.P. to release any information acquired in the course of my treatment that may be necessary to process my claim. (I permit a copy of this authorization to be used in place of the original.) In consideration of services rendered, I authorize payment to be made directly to ORTHOPAEDIC ASSOCIATES, L.L.P.

Patient Signature________________________________ Date_______________

ANESTHESIA AND HOSPITAL BILLS

You may also receive separate bills from one or other physician's offices. These bills may cover such expenses as physician services and/or professional interpretation of tests and X-rays. Questions concerning such bills should be directed to the office of the physician who sent the bill.

Patient Signature________________________________ Date_______________

USE OF A PHYSICIAN ASSISTANT OR CO-SURGEON

As deemed necessary by your physician, a physician assistant or co-surgeon may be necessary to provide the highest level of care during a surgical procedure. For such circumstances, you may be required to provide a surgery deposit for this individual in addition to your physician.

Patient Signature________________________________ Date_______________

MEDICARE PATIENTS

I hereby acknowledge that I am not a member of any Medicare HMO plan.

Patient Signature________________________________ Date_______________

ORTHOPAEDIC ASSOCIATES, L.L.P.

Orthopaedic Surgery & Sports Medicine

GREGORY P. HARVEY, M.D.

VIVEK P. KUSHWAHA, M.D.

ALAN J. RECHTER, M.D.

NAVIN SUBRAMANIAN, M.D.

DAVID L. LIN, M.D.

AMY E. RIEDEL, D.P.M.

JUSTIN CHRONISTER, M.D.

NOTICE OF PRIVACY PRACTICES

I have reviewed ORTHOPAEDIC ASSOCIATES, L.L.P.'s Notice of Privacy Practices, which explains how my medical information will be used and disclosed.

Patient Signature____________________________________ Date__________

I hereby give authorization to Orthopaedic Associates, LLP to release any or all information regarding my medical records to a designation of my choice:

Name__________________________ Relation to patient_________________

Patient Signature____________________________________ Date__________

CONSENT FOR RADIOGRAPHS (X-RAYS) / INJECTIONS

In the event that our orthopaedic surgeon requires an x-ray,

I, ______________________________ hereby authorize Orthopaedic Associates and Staff to perform RADIOGRAPHS of my ______________________________.

In the event that our orthopaedic surgeon recommends an injection,

I, ______________________________ hereby authorize Orthopaedic Associates and Staff to perform an INJECTION of my______________________________.

Patient Signature____________________________________ Date__________

Print Name: ________________________________

Orthopaedic Associates, L.L.P

Contract for Opioid Therapy

Our policy regarding the prescription of opioids for nonmalignant pain is strict and non – negotiable. Narcotics should only be used as an adjunct to other therapies and as a last resort after other treatment modalities have failed.

Our objective when prescribing narcotics are:

- To provide adequate analgesia with the least dose possible.
- To minimize side effects.
- To allow you to become more functional.
- To avoid abuse and addiction.

Please read the following 20 statements listed below

1. The goal of my medication plan is to discontinue the use of short action opioids (Vicodin, Lortab, Lorcet, and Norco) for chronic pain conditions.
2. Prescription refills will be done on an as needed basis, but no sooner than 10 (ten) days.
3. No refills will be made after clinic hours and on weekends or holidays.
4. I will use my medication only as prescribed. I will not take more than the amount indicated. Any evidence of such may result in termination of patient-physician relationship in OA.
5. I will not share my medications with anyone.
6. If I lose my medication, my prescription will not be replaced. Only in the event of extraordinary circumstances an exception will be made (i.e. your house burns down or you have a police report).
7. If my prescription is not refilled, I might experience a withdrawal syndrome. This means I may have any or all of the following: runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, irritability, aches throughout my body, and a flu-like feeling. I am aware that opioid withdrawal is uncomfortable but not life threatening. I may choose to seek medical attention at an emergency room.
8. While being a patient at OA, I will not receive prescriptions for opioids or other sedatives from any other licensed physician, unless it is authorized by OA. Any evidence of such will result in termination of the patient-physician relationship in OA.
9. I will not alter nor forge my prescriptions. Any evidence of such will result in termination of patient-physician relationship in OA.
10. I will use only **1 (one)** pharmacy to fill my medication.
11. I agree to provide a sample of my urine, and in some cases blood, for drug screening at my physician's request. Failure to do so will result in termination of the patient-physician relationship in OA.

12. Findings of other non-prescribed drugs in my urine or blood will result in termination of the patient-physician relationship in OA.

13. I am aware that **addiction** is defined as the use of a medicine even if it causes harm, having cravings for a drug, feeling the need to use a drug and a decreased quality of life. I am aware that the chance of becoming addicted to my pain medication is very low. I am aware that the development of addiction has been reported rarely in medical journals and is much more common in a person who has a family or personal history of addiction. I agree to tell my doctor my complete and honest drug history and that of my family to the best of my knowledge.

14. I understand that physical **dependence** is normal and expected result of using medicines for a long time. Dependence is not the same as addiction. I am aware physical dependence means that if pain medicine use is markedly decreased, stopped, or reversed by some agents (nalpuphine, buprenorphine, or stadol) I will experience withdrawal symptoms.

15. I am aware that **tolerance** to analgesia means that I may require more medicine to get the same amount of pain relief. Tolerance does not seem to be a big problem for most patients. If it occurs, increasing doses may not always help and may cause unacceptable side effects. This may cause my doctor to switch to another opioid or choose another form of treatment.

16. I am aware that the use of opioids has been associated with the following side effects:

    - Sleepiness and drowsiness
    - Nausea
    - Vomiting
    - Constipation
    - Urinary retention
    - Dizziness
    - Itching
    - Allergic reaction
    - Slow breathing/Slow reflexes and reaction times
    - Low testosterone levels in males

17. If the medications cause dizziness, sedation, or drowsiness, I understand I must not drive a motor vehicle or operate machinery that could put my life or someone else's in jeopardy.

18. Overdose of this medication may cause **death** by stopping my breathing.

19. I have read this contract or had it read to me. I understand all of it. I have had the chance to have all of my questions regarding this statement answered to my satisfaction. By signing this form voluntarily, I give ORTHOPAEDIC ASSOCIATES, L.L.P. my consent for the treatment of pain with opioid medications.

20. If I violate this agreement, my doctor will discontinue this form of treatment.

Patients Name: ______________________________

Patients Signature: ______________________________ Date Signed: ____________

Pharmacy: ______________________________ Phone #: ______________________

Dear Patient,

You are receiving this letter as notification of our prescriptive practices and compliance monitoring program regarding Schedule II medications.

The Drug Enforcement Administration (DEA) published a final rule of scheduling hydrocodone combination products from Schedule III to Schedule II on August 22, 2014. This rule will go into effect *October 6, 2014*. This ruling greatly restricts the ability of providers to prescribe hydrocodone products (Lortab, Norco, and Vicodin). This ruling will change our ability to prescribe hydrocodone products and provide refills. We have no control over many of the changes our practice is required to make that may unfortunately affect your postoperative care.

The DEA also strongly recommends the institution of a Medication Monitoring compliance program to ensure adequate protection of our patient's health and decrease drug related mortality and potential abuse or misuse.

The following changes will be put into effect in our practice due to the increased restrictions that accompany this schedule change:

- Schedule II medications (Norco, Vicodin, Lortab, Percocet) prescriptions must be written on an official prescription form. This means that we will no longer be able to call in prescriptions for this medication. The prescription must be physically picked up from our office.
- **We cannot legally provide phone refills on hydrocodone/oxycodone prescriptions.** Patients will be prescribed an adequate supply according to a schedule that will last until their next appointment. No refills will be given between appointments. If a refill is needed an appointment must be made Monday through Friday.
- **No "last minute" appointments for refills will be made on Fridays, no exceptions will be made.**
- If your prescription is lost or stolen, we will be unable to provide you with another prescription until your next scheduled appointment.
- You should expect that narcotic based medications will not be given any longer than six weeks after your last surgery. We will continue to try and treat your pain with non-narcotic modalities after six weeks. If you believe you will require hydrocodone/oxycodone beyond six weeks, it is advised that you establish care with a chronic pain or primary care physician as soon as possible and notify our clinic that another physician will be assuming care of your pain.
- You may be required to submit to a Medication Monitoring screening during appointments.
- Oral DNA samples may be required to evaluate patient susceptibility to medications.
- If you have a chronic pain physician, it is advised that you make an appointment as soon as possible, as you will not be able to receive the medication from multiple physicians. We will defer to your chronic pain physician for any postoperative narcotic prescription.

Should you have any questions or concerns, please contact your Physician or Nurse.

Sincerely,
Amy E Riedel, DPM

Please sign below to acknowledge receipt of information.

Patient signature: ______________________________ Date: ______________________

GREGORY P. HARVEY, M.D.
VIVEK P. KUSHWAHA, M.D.
ALAN J. RECHTER, M.D.
NAVIN SUBRAMANIAN, M.D.
DAVID L. LIN, M.D.
AMY E. RIEDEL, D.P.M.

FRACTURE CARE

In the event that our orthopaedic surgeon diagnoses you or your child with a fracture, the treatment of a fracture includes the clinical exam, reading of x-rays, casting/splinting, and following this injury until it has healed.

The charges associated with the care of a fracture (closed treatment of a fracture) are listed as a single charge. The code number and charges associated with this were developed by Medicare guidelines and your insurance company, not by our office. Your explanation of the benefits may describe it as a "surgery", but in reality it is not a surgery, but a closed (non surgical) treatment of the fracture.

The charge for this injury is a single charge that includes 90 days for follow up care, also known as the global period. It does not include charges for x-rays or casting materials. You will not be charged for an office visit every time you visit the doctor since this is included in your initial fracture care exam and fees.

Patient/Guarantor Signature

Date

A. Notifier: Dr. Amy Riedel, DPM

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** Nail Trimming below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** Nail Trimming below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
- Nail Trimming - Nail Debridement	- Not covered under benefits - Not within the coverage period (90 day period)	- Per insurance benefits.

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** Nail Trimming listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** Nail Trimming listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** Nail Trimming listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D.** Nail Trimming listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY**: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.