Patient Intake Form

Patient Name: ____ DOB: ______________ ICD: ____________

Patient Address: ____

Telephone: _______________________________ Height: ______Ft. _______In. Weight: _______________lb.

Check all applicable, then indicate LT (left), RT (right) or LTRT (bilateral):

Surgery Date: ___________

❑ Mastectomy _______ ❑ Partial Mastectomy _______ ❑ Reconstruction _______ ❑ Other _______

History of: (Check all applicable)

❑ Radiation ❑ Lymphedema ❑ Chemotherapy ❑ Other_______

Other Medical History: (Check applicable)

❑ ROM ❑ Arthritis ❑ Other ______________

Activity Level:

❑ Very Active ❑ Moderately Active ❑ Minimally Active

Ordering Physician Name: ____________________________________ NPI#: _______________

Ordering Physician Address: ____

Telephone: ____ Specialty: _________________

Reason for Visit: (Check applicable)

❑ Pre-Op ❑ Post-Op ❑ 1st Fitting After Surgery ❑ Refit ❑ Order Pick Up ❑ Routine Fitting

❑ Change in Condition ❑ New Surgery ❑ Replacement of Supplies ❑ Lost Supply

B & B'S HEALTH BOUTIQUE | 2217 PAPERMILL RD | WINCHESTER, VA 22601
(540)-313-4705—(F) (540) 773-4979 | NPI#14778570001

ASSIGNMENT-AUTHORIZATION-AGREEMENT

We are pleased that you have selected B&B's Health Boutique (B&BHB) to be your home medical provider for mastectomy products. Our hours of operation are 10:00 AM- 6:00 PM Tuesday, Thursday, Friday, 10:00 AM-4:00 PM Saturday, Closed Sunday, Monday and Wednesday.

HIPPA

1. Notice of Privacy Practice: I acknowledge that I have been offered/received a copy of B&BHB Notice of Privacy Practices and I understand my right to request a paper copy at any time in accordance with the Privacy Regulations of the Health Insurance Portability Act ("HIPPA"), the notice of Privacy Practices describes B&BHB company legal responsibilities with respect to my protected health information and it describe my rights under the HIPPA Privacy Regulations.

2. Medical Information Authorization: I hereby authorize any holder of medical information about me to release B&BHB any records pertaining to my medical history, services rendered, or treatment.

3. Permission for Disclosure and Use of Information: I consent to release B&BHB records to be reviewed by authorized representative of Medicare/Medicaid, Medicare intermediary, and/or private insurance companies for use in determining my home health benefits. Specifically, I authorize and request B&BHB to allow the individual/agency request to review my official records to examine my personal and medical records. I understand that I have the legal right by signing this consent shall be valid for whatever period of time is reasonably necessary for the individual/agency requesting to see my clinical records to fulfill the above-described purpose (s), or until I revoke this consent in writing, such a revocation of the consent shall have a prospective effect only.

4. ____ Beneficiary's initials. Also, I authorize B&BHB to disclose information regarding my equipment/supplies/medical information on my home answering machine/voice mail and to my spouse and children.

ASSIGNMENT OF BENEFITS & FINANCIAL RESPONSIBILITY

1. Authorization to Assign Benefits to Provider: I hereby request payment of my carrier to be made on my behalf to B&B's Health Boutique for products and services that are provided to me. I authorize the holder of medical information about me to release it for Medicare & Medicare Services and to its agents as its agents as the information is needed to determine these benefits payable for related services.

2. Acknowledgement of Financial Responsibility: While there may be insurance coverage for those services or products provided by B&BHB, some relative to my therapy needs, I recognize that all services may not be covered, or that reimbursement may be less than percent of charges billed, in accordance with my policy coverage. Therefore, I acknowledge financial responsibility for any balance owing on my account. In addition, I agree to be responsible for the full amount of the charges if no payment has been made 45 days necessary to submit the claim for services. I agree to transfer immediately to B&BHB any payment directly to me for services provided by B&BHB on an assigned basis.

MEDICARE SUPPLIER STANDARD STATEMENTS

1. Medicare Beneficiary Only: The products and or/services provided to you by B&B's Health Boutique 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://ecfr.gpoacess.gov. Upon request, we will furnish you a written copy of the standards.

PATIENT RIGHTS

The customer agrees that the equipment/supplies is accepted in its "as is" conditions (having been inspected by the customer upon delivery) B&BHB has not prescribed the equipment/supplies, and makes no representations or warranties of any kind, including with regard to merchantability or the fitness of the equipment/supplies for any particular purpose of the customer.

The undersigned certifies that he/she has read the foregoing, received a copy thereof, and is the patient, or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

Patient Name: ____

Signature: ______________________________ Date: __________________

Guardian Name: ____

Signature: ______________________________ Date: __________________