Patient Intake Form

Patient Name: _____ DOB: _____ ICD: _____

Patient Address: _____ __

Telephone: _____ Height: ____Ft. _____In. Weight: _____lb.

Check applicable, then indicate LT (left), RT (right) or LTRT (bilateral) Surgery Date: _____
☐ Mastectomy, _____ ☐ Partial Mastectomy, _____ ☐ Reconstruction, _____ ☐ Other_____
History of: (Check applicable) ☐ Radiation ☐ Lymphedema ☐ Chemotherapy ☐ Other_____
Other Medical History: (Check applicable) ☐ ROM ☐ Arthritis ☐Other _____

Activity Level: ☐ Very Active ☐ Moderately Active ☐ Minimally Active

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Ordering Physician Name: _____ NPI#: _____

Ordering Physician Address: _____

Telephone: _____ Specialty: _____

Primary Insurance:_____ Card holders name:_____
Policy number: _____ Group number: _____
Address:_____ Phone: (_____)_____-_____

Secondary Insurance: _____ Card holders name:_____
Policy number: _____ Group number: _____
Address:_____ Phone: (_____)_____-_____

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

Breast and Body Health Boutique
45 Featherbed Lane
Winchester, VA 22601
P: 540.313.4705 F: 540.773.4979

Covid-19 Questionnaire

1. Do you have any fever, or upper respiratory symptoms? e.g. Cough, sore throat or runny nose?	Yes No
2. Have you traveled out of state, or to an area with a known coronavirus outbreak within the past 14 days?	Yes No
3. Did you have any contact with patients confirmed with the Coronavirus disease within the past 14 days?	Yes No

Temperature: _____

Patient/customer printed name: _____

Patient/customer signature: _____

Today's Date: _____

B & B'S HEALTH BOUTIQUE
45 Featherbed Lane
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

2. **Patient Bill of Rights Disclaimer of Warranties**: 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: _____