

Care Crafters

PROSTHETICS & ORTHOTICS, INC.

A Division of Mobility Ideal Health

Patient

Care Crafters Prosthetics & Orthotics Inc, a division of Mobility Ideal Health is here to help restore your mobility. Our office requires the following to be able to help you:

You **MUST** have an **encounter** with your physician and the need for the device needs to be documented in the physician's **notes** (drop foot, low arches and foot pain, ambulation, gait deviations, etc.). The notes must also include how you ambulate (assisted, cane, walker, in- home, etc.). The doctor must provide a **cursory prescription**: eval and fit with [leg brace (AFO), prosthesis, footwear, custom orthotics, etc.].

Attached are three forms for you to complete and sign. Please fax or email ted@carecrafters.com along with enlarged copies of photo ID and insurance cards (both front and back).

- 1) Mobility Ideal Health patient information form
- 2) Patient consent for use and disclosure form
- 3) Records release form
- 4) Enlarged copies of photo ID and insurance cards (images of both front and back)

In the past few years, the number of different health insurance programs has increased at an amazing rate. Even within one company, there may be several programs with varying benefits and requirements. Some programs require pre-authorization, some require referrals, and some may pay a percentage of our charges, even in network.

Once we have the complete forms, cursory prescription, and patient encounter notes, we will call your insurance to help you understand the prosthetic and orthotic benefits of your plan and then call you to schedule an appointment. During the appointment, we will evaluate you, discuss options, and put a care plan in place, and possibly trial devices. Please call (845) 426- 6900 if there are any questions.

Thanking you in advance,

Thaddeus E. Drygas, CPO, FAAOP “At Care Crafters, we personalize the patient experience with dedication and quality craftsmanship.”

www.carecrafters.com

95 New Clarkstown Rd Suite101, Nanuet, NY 10954 | P: 845-426-6900 | F: 845-426-6926

[Mobility Ideal Health Group of Companies >](#)

[Ideal Health Care LLC](#) | [Mobility Clinic Inc.](#) | [Care Crafters Prosthetics and Orthotics Inc.](#) | [Green Prosthetics and Orthotics LLC](#) | [Professional Pulmonary Services \(PPS\) LLC](#)

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PATIENT REGISTRATION DATE: _____ **ID#:** _____ (*office use only*) **Initial:** _____

NAME: _____
(first) *(last)*

HOME ADDRESS: _____
(street) *(city)* *(state)* *(zip)*

CELL PHONE: _____ E-MAIL: _____

HOME PHONE: _____ WORK PHONE: _____

DATE OF BIRTH: _____ SEX: _____ MARITAL STATUS: (married) (single) (other)

HEIGHT: _____ WEIGHT: _____ DIABETIC? _____

EMERGENCY CONTACT: _____ PHONE: _____

REASON FOR VISIT: _____ DATE OF ONSET: _____

DO YOU HAVE ANY OTHER HEALTH ISSUES WE NEED TO KNOW ABOUT? _____

PRESCRIBING DR: _____ PHONE: _____ FAX: _____

PRIMARY DR: _____ PHONE: _____ FAX: _____

PHYSICAL THERAPIST: _____ PHONE: _____ FAX : _____

EMPLOYER: _____ OCCUPATION: _____

REFERRED BY: _____

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PRIMARY INSURANCE CO: _____

IS THIS AN HMO? PPO? _____ IS PRE-AUTHORIZATION NEEDED? _____

ADDRESS: _____

PHONE: _____ POLICY/CASE/PO# _____

INSURED: _____ INSURED DOB: _____

SECONDARY INSURANCE CO: _____

IS THIS AN HMO? PPO? _____ IS PRE-AUTHORIZATION NEEDED? _____

ADDRESS: _____

PHONE: _____ POLICY/CASE/PO# _____

INSURED: _____ INSURED DOB: _____

I authorize Care Crafters, division of Mobility Ideal Health, to release any information acquired during medical examination or treatment for insurance claim filing. I request that all insurance payments be made out to Care Crafters.

SIGNATURE _____ DATE: _____

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby consent to Care Crafters Prosthetics & Orthotics, Inc., a division of Mobility Ideal Health using and disclosing my protected health information (PHI) to carry out treatment, payment and healthcare operations (TPO). I hereby acknowledge that I have had the right to review Care Crafters Prosthetics & Orthotics, Inc.'s Privacy Policy prior to signing this consent, which provided me with a more complete description of potential uses and disclosures of my PHI. I am aware that Care Crafters Prosthetics & Orthotics, Inc. reserves the right to revise its Privacy Policy at any time. I am also aware that a revised Privacy Policy may be obtained by my forwarding a written request for same to Care Crafters Prosthetics & Orthotics, Inc.

Consent to Calls/Mail/Email

I hereby consent to Care Crafters Prosthetics & Orthotics, Inc. calling my home, cell phone or other designated location and leaving a message on my voicemail or in-person in reference to any items that assist Care Crafters Prosthetics & Orthotics, Inc. in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results and other matters incident to my treatment.

I hereby consent to Care Crafters Prosthetics & Orthotics, Inc. mailing to my home or other designated location any items that assist Care Crafters Prosthetics & Orthotics, Inc. in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

I hereby consent to Care Crafters Prosthetics & Orthotics, Inc. e-mailing me any items or communications that assist Care Crafters Prosthetics & Orthotics, Inc. in carrying out TPO, such as appointment reminder cards and patient statements. I understand that I have the right to request that Care Crafters Prosthetics & Orthotics, Inc. restrict how it uses or discloses my PHI to carry out TPO. However, Care Crafters Prosthetics & Orthotics, Inc. is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Care Crafters Prosthetics & Orthotics, Inc.'s use and disclosure of my PHI as specified in the Privacy Policy and this Patient Consent for Use and Disclosure of Protected Health Information.

I understand that I may revoke my consent in writing, except to the extent that Care Crafters Prosthetics & Orthotics, Inc. has already made disclosures in reliance upon my prior consent. If I do not sign this consent, I understand that Care Crafters Prosthetics & Orthotics, Inc. may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Patient's Name

Date

Phone Number(s) (Cell/Home/Work)

Email Address

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To Whom It May Concern:

Please accept this letter as my authorization to release my medical records to Care Crafters Prosthetics & Orthotics, Inc. located at 95 New Clarkstown Road in Nanuet, New York.

Telephone: 845-426-6900 – Fax: 845-426-6926.

Sincerely,

Name: _____

Address: _____

Birth Date: _____

Telephone: _____

Signature: _____

Date: _____

I understand I have the right to revoke this agreement, in writing, at any time.

*If signed by a Personal Representative, the following must be included:

Name of Personal Representative: _____

Description of Personal Representative's authority to act on behalf of patient

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