A Division of Mobility Ideal Health

Patient

Ideal Health Care LLC, 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 compete and sign. Please fax or email info@mobilityidealhealth.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 (732) 662- 5700 if there are any questions.

Thanking you in advance.

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PATIENT REGISTRATION **DATE:** DD-MM-YYYY *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: DD-MM-YYYY SEX: M/F MARITAL STATUS: (Married) ☐ (Single) ☐ (Other) ☐

HEIGHT: _____ WEIGHT: _____ DIABETIC? _____

EMERGENCY CONTACT: _____ PHONE: _____

REASON FOR VISIT: _____ DATE OF ONSET: DD-MM-YYYY

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: _____

PRIMARY INSURANCE CO: _____

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

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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 Green Prosthetics and Orthotics to release any information acquired during medical examination or treatment for insurance claim filing. I request that all insurance payments be made out to Green Prosthetics.

SIGNATURE _____ DATE: DD-MM-YYYY

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Patient Consent for Use and Disclosure of Protected Health Information

I hereby consent to Ideal Health Care LLC, 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 the right to review Ideal Health Care LLC's Privacy Policy prior to signing this consent, which provides me with a more complete description of potential uses and disclosures of my PHI. I am aware that Ideal Health Care LLC. 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 Ideal Health Care LLC.

Consent to Calls/Mail/Email

I hereby consent to Ideal Health Care LLC 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 Ideal Health Care LLC. 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 Ideal Health Care LLC. mailing to my home or other designated location any items that assist Ideal Health Care LLC. 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 Ideal Health Care LLC. e-mailing me any items or communications that assist Ideal Health Care LLC. in carrying out TPO, such as appointment reminder cards and patient statements. I understand that I have the right to request Ideal Health Care LLC. restrict how it uses or discloses my PHI to carry out TPO. However, Ideal Health Care LLC. 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 Ideal Health Care LLC'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 Ideal Health Care LLC has already made disclosures in reliance upon my prior consent. If I do not sign this consent, I understand that Mobility Clinic Inc may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Patient's Name

DD-MM-YYYY

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 Ideal Health Care LLC. located at 60 Lincoln Highway, Edison, NJ 08820.
Telephone: 732-662-5700 – Fax: 732-662-5699

Sincerely,

Name: _____

Address: _____

_____

Birth Date: DD-MM-YYYY

Telephone: _____

Signature: _____

Date: DD-MM-YYYY

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