BILLING OFFICE:
7570 US Hwy 42
Florence, Kentucky 41042
Local: 859-578-4822 Toll Free: 855-460-0956
FAX: 859-578-4828

DETAILED WRITTEN ORDER

Please Print ***CLEARLY***

AFFIX PRODUCT STICKERs) here

Qty:______Time of Need:______(months) Dx: ____________________

____
Prescribing Clinician Name (print) NPI

x______________________________
Prescribing **Clinician Signature (**No Stamp) **Date**

PATIENT INFORMATION or sticker ** attach demographics/face sheet

Patient Name: ______________________________

DOB:____________________Last 4 of SS Number: ____________

Street Address: ______________________________

City:______________________State:__________Zip: __________

Cell Phone: ______________________________

Email:______________________________

Responsible Party: ______________________________

Relationship to Patient: ______________________________

CPM DELIVERY/SET-UP

☐ **L** ☐ **R** ☐ **B/L**
☐ **Knee** ☐ **Shoulder**

Beginning ROM: ____________________

Ending ROM: ____________________

Instructions Given to: ____________________

____________________Hours/Day: ____________________

*Date:*____________________Increases/Day: ____________________

Patient understands (1) safe device operation; (2) device settings; (3) when to contact their attending physician; (4) how to contact Advanced Technology of Kentucky for complaints, concerns and/or service needs; (5) how to contact Advanced Technology of Kentucky for pick-up at the end of rental period; (6) the Provider Privacy Practices; (7) Medicare Supplier Standards; and (8) financial responsibility for CPM pads and other disposable supply for device usage in addition to device rental.

Before leaving the delivery location, the Provider has ensured (1) proper electrical outlet is present; (2) hand controller is within reach of patient; (3) patient instructions have been given and patient affirms understanding; (4) device is fully operational; (5) device cord is not obstructed; (6) device is secure in current location and (6) patient kit is applied appropriately.

INSURANCE INFORMATION or attach Insurance card copies

Carrier:______________________________Type:______________________________

Member ID:______________________________Group ID: ______________________________

Member Name:______________________________Relationship to Patient: ____________________

Member DOB:______________________________Member Employer: ____________________

PATIENT FINACIAL AGREEMENT

Must be Signed and Dated by Responsible Party

Proof of Delivery: *The patient or responsible party("I") acknowledges receipt/proof of delivery of the Durable Medical Equipment specified on this Standard Written Order. I do confirm on this day I am in receipt from Advanced Technology of Kentucky Inc. ("ATI") or an Advanced Technology of Kentucky Inc. affiliate ("Provider"), the product listed about and participated in the plan of care. I confirm I have also been provided (1) written and verbal instructions on proper use, care and maintenance of the product provided; (2) access to the Medicare Supplier Standards; (3) access to the Patient Bill of Rights; (4) Provider's Notice of Privacy Practices; (5) warranty information; (6) return policy; and (7) contact information for questions or complaints.*

Refusal: *I understand that I may refuse delivery of this product.*

Consent for Treatment: *I consent to treatment by the Provider. I understand and agree that (1) my care is under the supervision and control of my attending physician; (2) my physician has prescribed the product and services delivered to me today as part of my treatment; (3) my physician has explained the risks, advantages, complications and alternatives to this product. (4) my physician has explained why this treatment is considered medically necessary as treatment for my condition (5) the Provider's services do not include diagnostic testing, prescriptive rights and other functions pertaining to licensed physicians; and (5) only my physician is solely responsible for diagnosing and prescribing drugs, product and therapy for my condition or otherwise supervising and controlling my medical condition.*

Assignment of Benefits: *I consent to billing by the Provider and request any payment authorized by Medicare, Medicaid, supplemental insurance, Medigap, and/or other third-party insurance policies which is made on my behalf be directed to the Provider for the products delivered to me on this date.*

Release of Information: *I agree to provide all documents and information necessary for the Provider to obtain direct payment from Medicare, Medicaid and/or other third-party payers. I hereby authorize the release of my medical information to determine and obtain insurance benefits for products and services provided to me by the Provider. I authorize the Provider to appeal denied insurance authorizations or benefits on my behalf.*

Financial Responsibility: *I understand and agree that (1) I am financially responsible to the Provider for payment of applicable deductibles, co-insurance, or other amounts assigned by Medicare, Medicaid and other third-party payers as my financial responsibility; (2) I am financially responsible for any product or services delivered to me that are not reimbursed by Medicare, Medicaid and/or other third-party payers; unless otherwise prohibited by contract or law; (3) any amount owed will vary based on my insurance plan, whether my deductible has been reached, if I have co-insurance amounts, if an item is reimbursable by my plan, network status of my plan, and/or if I have secondary coverage; (4)I agree to transfer immediately to the Provider any payments made to me directly from Medicare, Medicaid, and/or other third-party payers for the products and/or services provided to me in whole or in part; and (5) if I am unable to pay my responsibility in full, I will contact the Provider at the information listed above to establish a payment plan and/or apply for income-based financial assistance.*

Email and Cell Phone Acknowledgment: *By providing my email and cell phone information I (1) authorize the Provider to contact me by those methods regarding the care and services I have received; (2) my information will not be used or sold for any other purpose. (3) Portions of the correspondence may not be encrypted; therefore, the Provider cannot ensure the security of any information sent or received via email or text (4) will refer any questions regarding my rights to the Providers Notice of Privacy Practices*

Patient/Responsible Party Signature:______________________________**Date:** __________

Print Name:______________________________Relationship to Patient: ____________________

PAYMENT INFORMATION

Item Cost: $__________Payment Method:__________________Representative:__________________**Location:**__________________

Name as it Appears on Card:______________________________Card Number: ____________________

Expiration Date:____________________Security Code:____________________Billing Zip Code: ____________________

Card Holder Signature:______________________________Date: __________

PATIENT BILL OF RIGHTS

You have the right to:

- Review your clinical record and request a copy, a signed release form is required
- Request an amendment or correction to our record
- Request limits or restrictions on the release of your records (carrier, legal, and health department requests are exempt)
- Request an accounting of who your records have been released to
- Received service from ATI regardless of race, religion, color, age, gender, handicap, sexual orientation, veteran status, or lifestyle
- To be informed on any out-of-pocket expenses with a good-faith estimate based on information obtained from your insurance
- Receive clear instructions on the safe use of all products, equipment or treatment protocols ordered by your physician
- Know the name and qualifications of the individual providing the ordered product, equipment or treatment protocols
- Be informed of the service to be delivered and be informed of your right to refuse delivery of the product, equipment or treatment protocol
- Receive services directly from ATI or via contract
- Participate in the planning and development of your treatment plan or protocol
- Be referred to another supplier for any reason
- Expect and receive kind treatment from all employees of Advanced Technology of Kentucky, Inc
- Expect your property to be treated with respect
- Be informed that Advanced Technology of Kentucky, Inc is a privately held organization which maintains appropriate levels of liability insurance as required under statute, contract and accrediting body
- Be informed that Advanced Technology of Kentucky, Inc does not have any beneficial relationships which result from referring other organizations to a patient or family member of the patient
- Be informed that you may contact the Community Health Accreditation Program (CHAP) at 800-656-9656 to lodge a complaint if you feel as if your rights have been violated. You will receive a response to any lodged complaint regarding the investigation of the complaint and any resolution of said investigation
- Be informed that you may express satisfaction, concern or upset with any aspect of your care, employee conduct, product performance, equipment set-up, treatment protocol or related services by calling our office at 855-460-0856 between the hours of 8:00am and 5pm EST, Monday – Friday.
- Be informed that you may express satisfaction, concern or upset with any aspect of your care, employee conduct, product performance, equipment set-up, treatment protocol or related services in writing to: Office Manager, C/O ATI, 7570 US HWY 42, Florence, KY 41042-2324.

RETURN POLICY

Advanced Technology of Kentucky, Inc does not accept returns of any kind. Durable medical equipment is considered a single use product and Advanced Technology of Kentucky, Inc is forbidden from re-selling a used product. In the event of manufacturer defect, or a poor fitting product, please call the office at 859-578-4822 between the hours of 8:00am and 5:00pm EST to arrange an exchange.

RENTAL POLICY

Advanced Technology of Kentucky, Inc does offer some rental products. You will be educated on safe use, troubleshooting, delivery and pick-up. In most cases, there will be a time period authorized by your insurance carrier and/or treatment plan. Any amount of time the rental item is kept by the patient, that is not the result of pick-up arrangements by Advanced Technology personnel, the patient will be charged for the excess time. ***RENTAL PRODUCTS MUST BE RETURNED IN GOOD WORKING CONDITION***. Damaged rentals will be charged full purchase price.

In the event you have had a rental product for sufficient time to have paid the purchase price, Advanced Technology of Kentucky, Inc will convert the billing to a purchase and the patient will no longer be charged the recurring rental amount.

PATIENT RESPONSIBILITIES

As the patient, or designated signer, you agree to the following responsibilities:

- The patient cannot modify any product without written permission of Advanced Technology of Kentucky, Inc
- The patient is responsible for arranging pick-up or drop-off of rental items
- The patient may not allow the use of any product, equipment, or treatment protocol to anyone else
- The patient is responsible for any non-covered items, co-payment, co-insurance, deductible, or out-of-pocket expenses as assigned by their insurance carrier
- The patient will be financially responsible for the replacement of any damaged rental products beyond normal wear-and-tear
- The patient will be financially responsible for the replacement of any lost or stolen rental product
- The patient must notify Advanced Technology of Kentucky, Inc of any product, equipment or treatment protocol that malfunctions or causes loss and injury
- The patient will allow Advanced Technology of Kentucky, Inc an appropriate, agreed upon, timeframe to repair or replace defective or malfunctioning product, equipment, or treatment protocol.
- The patient understands that Advanced Technology of Kentucky, Inc will submit insurance claims on your behalf
- The patient understands that any questions about their insurance plan including: coverage limits, deductibles, co-insurance, co-pays and out-of-pocket assignments should be directed to their insurance carrier directly
- The patient understands that regardless of insurance “coverage” there are certain products, equipment and treatment protocols that we do not bill to insurance. This policy may be due to any reason, and it applied systemically across all patients. No exceptions will be made.
- The patient understands that any product, equipment or treatment protocol they accept delivery of will be their responsibility financially.
- The patient understands their signature acknowledges the policies, procedures and rights as described

FOR MORE INFORMATION

VISIT OUR WEBSITE www.atiortho.com

Call Us: 859-578-4822

Email: info@atiortho.com

Set up your Patient Account: https://ati.hmebillpay.com/

DME SUPPLIER STANDARDS and PRIVACY POLICY: