ATI MEDICAL SUPPLIES
EMPOWERING • SUPPORTIVE • DEPENDABLE

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

AFFIX PRODUCT STICKERs) here

Qty:_____Time of Need:_____(months) Dx: _____

_____
Prescribing Clinician Name (print) NPI

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

RIGHT or LEFT (circle one)

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 FINANCIAL 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 AND RESPONSIBILITIES

Scan QR Code for Medicare DME Supplier Standards and our Privacy Policy

ATI **must disclose your PHI to federal, state, and local authorities as required by law.**

Protected Health Information (PHI) – you have the right:

- To review your PHI and obtain a copy.
- To request an amendment and correction of your PHI.
- To request limits or restrictions on ATI's release of your PHI.
- To request an accounting to whom ATI released your PHI.

Your financial information is considered to be part of your PHI. Please read ATI's Notice of Privacy Practices for a full disclosure of your rights under the Health Insurance Portability and Accountability Act of 1996.

You have the right to:

- Obtain service regardless of race, religion, color, age, gender, handicap, sexual orientation, veteran status or lifestyle.
- Be treated in such a manner that is free from any type of abuse, neglect, damage to or theft of property, and exploitation of any kind.
- Know maximum charges for services including fees covered by patient and those covered by Medicare, State Medicaid, Commercial insurance, and/or other third party.
- Receive considerate and respectful service.
- Be advised if charges increase from those stated at the time of service.
- Know that ATI is a privately held corporation that maintains liability insurance. Also know that ATI does not have any beneficial relationships that results in profit for referring organizations.
- Receive clear instructions in the use of all products, equipment and protocols ordered by your physician.
- Know the name and qualifications of the individual providing service.
- Receive a response to a lodged complaint in regard to the investigation review and resolution of the complaint.
- Express your concerns or grievances with any aspect of care, employees, products or equipment or any company related services by calling **Customer Service at (859) 578-4822** (8:00am – 5:00 pm EST Monday – Friday) or writing to: **ATI Medical Supplies 7570 US Highway 42 Florence,KY 41042 other options - CMS 1-800-Medicare, BOC 1-877-776-2200 or State Hot line 859-246-2301.**

Your responsibilities include the following:

- Care for, use as instructed, and return equipment in good condition. Normal wear is expected at the end of the rental period.
- Pay for replacement cost of any rental equipment that was damaged, destroyed, or lost due to misuse, abuse, or neglect.
- Do Not modify any equipment without prior written consent of ATI.
- Do Not allow the use of any equipment by anyone other than the patient.
- Notify ATI promptly if any equipment malfunctions and/or allow an ATI representative to repair or provide replacement equipment within an agreed upon timeframe.
- Supply ATI with needed insurance information necessary to obtain payment for services and assume responsibility for charges not covered, including deductibles and co-payments. You are responsible for the bill regardless of insurance coverage.
- Make a payment within 15 days of receipt of the invoice; failure to pay could result in further collection activities including interest and collection fees.
- Make informed decisions about your services.
- You are responsible for contacting ATI promptly to arrange for rental pick-up. Please call (859) 578-4822 to schedule a pick-up.

INSURANCE AND BILLING INFORMATION

The ATI billing department will bill your insurance company for the services you receive from us. If you have coverage from more than one health insurance company, please specify which company is primary and should be billed first. Since each health insurance policy varies, we suggest you call your insurance company if you have any questions regarding coverage. We hope to make the billing process trouble free. Regardless of insurance coverage, you are responsible for your bill. If your insurance carrier has questions or requests additional information from you, please respond promptly. If you have any questions regarding the status of your claim, contact your insurance company directly. The billing department is ready to answer billing and insurance questions and can be reached at (859) 578-4822 Monday-Friday, 8:00 am – 5:00 pm (EST). You may leave a message outside of business hours and your call will be returned on the next business day.