Medical Art Prosthetics, LLC®

MedicalArtProsthetics.com • 608-833-7002

MAIN OFFICE: 7818 Big Sky Drive, Suite 111
Madison, Wisconsin 53719
CHATTANOOGA • CHICAGO • LOS ANGELES
MADISON • NEW JERSEY • ROCHESTER • SAN JOSE

Thank you for choosing Medical Art Prosthetics, LLC. Please fill out the enclosed forms prior to your appointment. If you have questions or are unable to do this, please arrive 15 minutes prior to your scheduled appointment time so we can assist you.

Please bring the following items to your appointment:

- Current insurance cards (if applicable)
- Form of identification (drivers license, ID card, passport)
- Form of payment (cash, check, VISA or MC)
- Enclosed forms
- Medical records from physician to show medical necessity (if applicable)

We look forward to serving you.
Sincerely,

PRACTITIONERS AT THE MEDICAL ART PROSTHETICS NETWORK

Gregory Gion
MMS, CCA, BOCP
Anaplastologist
Prosthetist

McKenzie Bergenback
MS
Medical Artist
Anaplastologist

James Hogue
MS, CCA
Medical Artist
Anaplastologist

Shay Kilby
MS
Medical Artist
Anaplastologist

Todd Kubon
MAMS, CCA
Medical Artist
Anaplastologist

Maddie Singer
BFA, BA
Fine Arts
Anaplastologist

Your appointment is scheduled for:

Date: _____ ***Time:*** _____

Please let us know in advance if you need to reschedule or cancel your appointment.

Medical Art Prosthetics, LLC®
MedicalArtProsthetics.com • 608-833-7002

MAIN OFFICE: 7818 Big Sky Drive, Suite 111
Madison, Wisconsin 53719
CHATTANOOGA • CHICAGO • LOS ANGELES
MADISON • NEW JERSEY • ROCHESTER • SAN JOSE

PATIENT INFORMATION

Patient Name: _____ **Date of Birth:** _____ **Age:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Social Security #: _____ **Sex:** ☐ **M** ☐ **F** **Email:** _____

☐ **Married** ☐ **Single** ☐ **Widowed** ☐ **Divorced** ☐ **Partnered** ☐ **Minor**

Home Phone: _____ **Cell Phone:** _____ **Today's Date:** _____

Emergency Contact Name: _____ **Phone:** _____ **Relation:** _____

INSURANCE INFORMATION

Name of Insured: _____ **Relation to patient:** _____

Birthdate: _____ **Social Security #:** _____ **Date Employed:** _____

Employer: _____ **Work Phone:** _____

Employer Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Insurance Company: _____ **ID #:** _____ **Group #:** _____

RESPONSIBLE PARTY- Please fill out if patient is not the primary insurance holder.

Name of person responsible for this account: _____ **Relation to patient:** _____

Address: _____ **Phone:** _____

Birthdate: _____ **Is responsible party a patient in our office?** ☐ **Yes** ☐ **No**

Employer: _____ **Work Phone:** _____

Email: _____ **Cell Phone:** _____

Medical Art Prosthetics, LLC®
MedicalArtProsthetics.com • 608-833-7002

MAIN OFFICE: 7818 Big Sky Drive, Suite 111
Madison, Wisconsin 53719
CHATTANOOGA • CHICAGO • LOS ANGELES
MADISON • NEW JERSEY • ROCHESTER • SAN JOSE

SECONDARY INSURANCE INFORMATION

Name of Insured:_____**Relation to patient:**_____

Birthdate:_____**Social Security #:**_____**Date Employed:**_____

Employer:_____**Work Phone:**_____

Employer Address:_____ **City:**_____**State:**_____**Zip:**_____

Insurance Company:_____**Group #:**_____**Union or Local #**_____

ASSIGNMENT OF BENEFITS AND FINANCIAL POLICY

INSURANCE:

It is your responsibility to know the details of your particular insurance policy. Not all services are covered by all carriers. Services which are not covered by your insurance are your responsibility. If your insurance has a co-payment policy, payment is due at the time of service. This includes applicable co-insurance, co-payments and deductibles for participating insurance companies. If you have a deductible, you are responsible for all charges until the deductible is met. It is also your responsibility to make us aware of any restrictions your policy has on ancillary services (such as requiring a specific lab test). If you have multiple insurance policies (secondary insurance) you are also responsible for coordination of benefits.

It is your responsibility to make sure we have accurate insurance carrier information and billing information.

We bill insurance companies as a courtesy to you. If we are unable to verify your insurance or you do not have your insurance card, full payment is due at the time of service. You are responsible to be sure all charges are paid whether by you or by your insurance carrier. We will also bill secondary insurance companies as a courtesy to you. Your time of service receipt includes all information necessary for submitting claims to your insurance company.

If your insurance carrier has a network of providers, it is your responsibility to make sure that we are an "in network" provider prior to obtaining services. If we are not "in network," we will still be happy to provide services; however, the percentage of charges for which you are responsible for may be greater. Some insurance companies do not cover any "out of network" services. If your insurance company denies payment due to "out of network" services, you are responsible for payment.

PAYMENTS:

All payments are due at the time of service unless other arrangements have been made in advance. Initial new patient consults are $200 and due at the time of service. If you decide to move forward with a prosthesis, ½ of the total cost is due up front and the remaining ½ is due when the prosthesis is delivered to you. You may also be required to pay a non-refundable deposit. Medical Art Prosthetics, LLC accepts cash, personal checks, VISA, and MasterCard. There is a service charge for returned checks. Patients with an outstanding balance 60 days or more overdue must make arrangements for payment prior to scheduling additional appointments and patients are responsible for any outstanding balances after 120 days. If you need assistance or have questions, please contact the Billing Coordinator between 9:00 a.m. and 2:00 p.m., Monday through Thursday at 608-833-7002.

Medical Art Prosthetics, LLC®
MedicalArtProsthetics.com • 608-833-7002

MAIN OFFICE: 7818 Big Sky Drive, Suite 111
Madison, Wisconsin 53719
CHATTANOOGA • CHICAGO • LOS ANGELES
MADISON • NEW JERSEY • ROCHESTER • SAN JOSE

REFUNDS:

Patient/guarantor credits in amounts less than $20.00 will be retained on account to be credited toward future balances unless a written request for refund is received. Amounts $20.00 and greater will automatically be refunded to the patient/guarantor.

MISSED APPOINTMENTS/LATE CANCELLATIONS:

Broken appointments represent a cost to us, to you, and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. We reserve the right to charge for missed or late-canceled appointments. Excessive abuse of scheduled appointments may result in discharge from the practice.

I have read and understand the Medical Art Prosthetics, LLC Financial Policy. I agree to assign insurance benefits to the Medical Art Prosthetics, LLC practice whenever necessary. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for the cost of collection.

_____ _____

Signature of insured or authorized representative **Date**

_____

Printed Name

PATIENT AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION:

I understand that under the Health Insurance Portability and Accountability Act (HIPAA)of 1996, I have certain rights to privacy regarding my protected health information (PHI). I understand that my protected health information will be disclosed or used for treatment, payment, and healthcare operations. This may also include coordination of care with other medical facilities, healthcare providers, administrative personnel, and insurance companies. Medical Art Prosthetics, LLC (the Practice) may also use my personal information to contact me via phone, letter, or email. I understand the Practice routinely leaves messages regarding appointment reminders or requests to call the office, but specific details of my personal health information will only be discussed directly with me or mailed to my home address in a sealed envelope. I understand Medical Art Prosthetics, LLC will not discuss my protected health information with any third parties without my prior authorization. I understand I have the right to request confidential communication or specific changes in how the Practice contacts me. The Medical Art Prosthetics, LLC Notice of Privacy Practices is a more complete description of the uses and disclosures of my protected health information and outlines my rights as a patient. By signing below, I acknowledge that I understand my rights as a patient and have received, or declined to receive, a full printed or electronic copy of the Medical Art Prosthetics, LLC Notice of Privacy Practices. I also understand at any time I may request a copy of this document.

Medical Art Prosthetics, LLC®
MedicalArtProsthetics.com • 608-833-7002

MAIN OFFICE: 7818 Big Sky Drive, Suite 111
Madison, Wisconsin 53719
CHATTANOOGA • CHICAGO • LOS ANGELES
MADISON • NEW JERSEY • ROCHESTER • SAN JOSE

If you would like to authorize Medical Art Prosthetics, LLC to discuss your protected health information with a third party, please initial and identify the person(s) below. Otherwise leave blank.

I authorize Medical Art Prosthetics, LLC and its representatives to discuss any and all protected health information (PHI) contained in my complete medical record as well as to discuss any insurance and billing information related to my healthcare with the following person(s):

_____ **Patient Initials**

_____

PRINTED NAME RELATIONSHIP

_____

PRINTED NAME RELATIONSHIP

This authorization will remain in effect indefinitely unless directed by me via verbal or written instructions to terminate the authorization, or unless a specific termination date is listed below.

This authorization will expire on: _____

_____

PRINTED NAME OF PATIENT

_____

Printed name or parent/guardian (if patient is a minor) or printed name of healthcare power of attorney (if applicable)

_____

SIGNATURE OF PATIENT OR REPRESENTATIVE DATE

Medical Art Prosthetics, LLC®
MedicalArtProsthetics.com • 608-833-7002

MAIN OFFICE: 7818 Big Sky Drive, Suite 111
Madison, Wisconsin 53719
CHATTANOOGA • CHICAGO • LOS ANGELES
MADISON • NEW JERSEY • ROCHESTER • SAN JOSE

PATIENT INFORMATION

Patient Name: _____ **Date of Birth:**_____ **Age:**_____

Type of Prosthesis Needed:_____

Cause: ☐ Congenital ☐ Traumatic Injury ☐ Disease and/or Surgery

Diagnosis:_____ **Date of injury/surgery:**_____

Referring Physician: _____ **Phone:** _____

Address: _____ **City, State, Zip:** _____

Do you have or have you ever had: (check all that apply)

☐ Diabetes ☐ Eczema/Psoriasis ☐ Arthritis ☐ HIV + AIDS ☐ MRSA ☐ Seizures

☐ Chemo ☐ Keloid formation ☐ Radiation Therapy ☐ Hyperbaric oxygen

ALLERGIES: ☐ None

☐ Aspirin ☐ Novocaine/anesthetic ☐ Iodine ☐ Latex ☐ Penicillin ☐ Sulfa

☐ Topical antibiotics (Neosporin/bacitracin) Other _____

Smoker? ☐ No ☐ Yes - Pack per day/ years of smoking:_____

Do you drink alcohol? ☐ No ☐ Yes - Drinks per week_____

Medical Art Prosthetics, LLC®
MedicalArtProsthetics.com • 608-833-7002

MAIN OFFICE: 7818 Big Sky Drive, Suite 111
Madison, Wisconsin 53719
CHATTANOOGA • CHICAGO • LOS ANGELES
MADISON • NEW JERSEY • ROCHESTER • SAN JOSE

CURRENT MEDICATIONS: _____

_____

_____

_____

_____

_____

To the best of my knowledge the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I or my minor child has any changes in health.

_____

Signature of Patient, Parent, Guardian or Personal Representative **Date**

_____

Printed Name of Patient, Parent, Guardian or Personal Representative

_____

I certify that I have reviewed the above information: Provider Signature

Medical Art Prosthetics, LLC®
MedicalArtProsthetics.com • 608-833-7002

MAIN OFFICE: 7818 Big Sky Drive, Suite 111
Madison, Wisconsin 53719
CHATTANOOGA • CHICAGO • LOS ANGELES
MADISON • NEW JERSEY • ROCHESTER • SAN JOSE

PHOTO CONSENT

I hereby give Gregory G. Gion, his legal representatives and assigns, those for whom Gregory G. Gion is acting, and those acting with his authority or permission, the absolute right and permission to copyright and/or use, re-use and/or publish, or republish, photographs or photographs of me, or photographs in which I may be included in whole or in part, or composite photographs in color or otherwise, made through any media at his studios or elsewhere for art, advertising, education, medical/legal records, or any other lawful purpose. I consent to the use of any printed matter in conjunction therewith.

I give my permission for photographs, which may be taken on subsequent visits. I hereby release, discharge and agree to save harmless Gregory G. Gion, his legal representatives or assigns, and all persons acting under his permission or authority or those for whom he is acting, from any liability with regard to being photographed.

I hereby warrant that I am of full age and have every right to contract in my own name in the above regard. I hereby state further that I have read the above authorization, release and agreement, prior to its execution, and that I am fully familiar with the contents thereof.

Legal Signature: _____ **Date:** _____

Name: (Please Print) _____

Address: _____

Parent or Legal Guardian

Name: _____

Address: _____