New Patient Information

Date _____/______/_____ Referred By ______________________ Family Physician____________________

Name____
(first) *(middle)* *(last)*

Address (*NO PO Box*)____

City ______________________________ State ________________ ZIP _________________

DOB: ______/______/______ SSN______-______-________ Martial Status: S M D W SEP

Home Phone ( )_______________________ Work/Alternate ( ) ________________________

Email____

Date of Surgery ____/_____/_______ ☐LT ☐ RT Bra Size_______________

Surgery Type: PARTIAL MASTECTOMY (LUMPECTOMY) TOTAL MASTECTOMY RECONSTRUCTION

Surgeon____________________ Office Location_________________________ Phone_____________________

Primary Insurance____

Secondary Insurance____

☐ ASSIGNMENT OF INSURANCE TO PROVIDERS: I AUTHORIZE DIRECT PAYMENT OF MEDICAL BENEFITS TO THE ATTENDING PROVIDER. THE BENEFITS REFERRED TO HEREIN WOULD BE PAYABLE TO ME IF I DID NOT MAKE ASSIGNMENT AND INCLUDE MAJOR MEDICAL INSURANCE. I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR ANY/ALL CHARGES INCURRED BY ME, THIS INCLUDES ITEMS ABOVE THE INSURANCE ALLOWABLE/DEDUCTIBLE/CO-INSURANCE AS WELL AS INSURANCE DENIAL OF CLAIM.

THE ATTENDING PROVIDER IS AUTHORIZED TO RELEASE ANY MEDICAL INFORMATION REQUIRED IN THE ADMINISTERING OF APPLICATIONS FOR FINANCIAL COVERAGE FOR SERVICES RENDERED. HE MAY ALSO SEND THE RESULTS OF MY EVALUATION AND RECOMMENDATIONS TO MY REFERRING AND/OR FAMILY PHYSICAN FOR COORDINATION AND CONTINUITY OF CARE. I HAVE CAREFULLY COMPLETED THIS FORM AND TO THE BEST OF MY KNOWLEDGE IT DOES NOT CONTAIN ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION.

☐ I DO NOT ASSIGN BENEFITS TO THE PROVIDER, AND I UNDERSTAND THAT I MUST PAY IN FULL FOR ALL SERVICES PROVIDED TO ME.

☐ I DO NOT AUTHORIZE THE RELEASE OF ANY MEDICAL RECORDS FOR BILLING OR REFERRAL PURPOSES AND UNDERSTAND THAT THIS MEANS THE PROVIDER WILL NOT BILL MY INSURANCE FOR ME.

I HAVE RECEIVED A COPY OF JPE ENTERPRISES, INC. (A PERFECT FIT) PRIVACY PRACTICES AND MEDICARE SUPPLIER STANDARDS ON THE ABOVE NOTED DATE AND UNDERSTAND THAT ANY QUESTIONS I HAVE WILL BE ANSWERED BY THE STAFF IN THEIR OFFICE.

Name ____
(print)

Signature____

JPE Enterprises, Inc.
5001 N Kings Hwy. Suite 101
Myrtle Beach, SC 29577

rev. 2/2021

JPE Enterprises, Inc.

Perfect Fit Boutique
5001 N. Kings Hwy., Suite 101
Myrtle Beach, SC 29577-2556
843-692-2555

Authorization for Release of Medical Records

I hereby authorize the following doctor(s):

____

____

____

____

Release my medical records to:

Perfect Fit Boutique, DBA / A Perfect Fit
5001 N. Kings Hwy., Suite 101
Myrtle Beach, SC 29577-2556

fax: 843-692-9976 *email:* billing@perfectfitboutique-mb.com

The information to be released includes any diagnosis, treatment, and examination rendered to me. This authorization is considered valid until revoked in writing.

____________________________	__________________
Patient Signature	*Date*
____________________________	__________________
Printed Name	*Date of Birth*
____________________________	
Patient Social Security Number	

JPE Enterprises, Inc., DBA A Perfect Fit
5001 N. Kings Hwy., Suite 101
Myrtle Beach SC 29577

Phone 843-692-2555
Fax 843-692-9976
Email billing@perfectfitboutique-mb.com

Date ________________

Length of Time: 12 Months

Patient Name ____

DOB ______________________

Dx. Code ____

Surgical Side: LEFT RIGHT BILATERAL

Detailed Written Order for Prosthetic Devices

Quantity Ordered	HCPCS Code	Detailed Description
____________	L8035	Custom prosthesis, post mastectomy, molded to patient model
____________	L8030	Breast prosthesis, post mastectomy, silicone or equal without integrated adhesive
____________	L8020	Breast prosthesis, post mastectomy, foam or beaded
____________	L8000	Mastectomy bra without integrated breast form or prosthesis
____________	L8001	Mastectomy bra with integrated breast form/prosthesis unilateral
____________	L8002	Mastectomy bra with integrated breast form / prosthesis bilateral
____________	L8015	External breast prosthesis garment / camisole with integrated breast forms

Ordering Physician's Name ______________________________ NPI Number ______________________
Please Print

Physician Signature____________________________________ Date Signed ______________________

Address____

____

Phone ______________________________

Please Note: Signature and/or date stamps are no longer accepted by Medicare.
Medicare & Blue Cross also require last office note sent with signed DWO.

rev. 2/2021

Insurance Coverage Notice

Please Note:

It is the patient's responsibility to know their own insurance coverage.

Our office will submit the charges for services rendered to Medicare, Medicaid, and all other insurance companies. This does **NOT** mean we participate with your insurance or accept their allowed charges as full payment.

We will do our best to verify benefits through your primary insurance, however it has become an unrealistic burden for us to know and/or verify secondary insurance policies.

The patient is responsible for all deductibles, co-pays, and co-insurance due. We reserve the right to collect these at the time of service, this includes any applicable Medicare deductible and co-ins as several secondary payers have not been paying these claims. If you need additional information, please contact your insurance company by calling the customer service telephone number provided on your card.

If your payment method is by check and it is returned to us for any reason, (NSF, stop payment, or otherwise) you will be subject to a fee of $35.00 or 5% of the check amount, whichever is greater. If this matter is not resolved within 15 days, we will submit your insufficient check to the "Worthless Check Department of Horry County" for collection action.

Thank you,

JPE Enterprises, Inc.
d/b/a A Perfect Fit

______________________________ ________________
Signature *Date*

____
Name, printed

rev. 2/2021

JPE Enterprises, Inc.

Perfect Fit Boutique
5001 N. Kings Hwy., Suite 101
Myrtle Beach, SC 29577-2556
843-692-2555

Notice of Return Policy

We have a policy of **NO RETURNS and/or NO EXCHANGES** under any circumstances. This policy includes all items which would be billed to your insurance company (*bras, prosthesis, perma-bras, and camisoles).*

Thank you,

JPE Enterprises, Inc.
DBA-A Perfect Fit

I have read and agree to the above policy.

Date___________________

Name ____
(print)
Signature____

I have received a copy of this policy.

Date___________________

Name ____
(print)
Signature____

Patient SSN _______________________________________

J.P.E. ENTERPRISES, INC. D/B/A/ A PERFECT FIT
PRIVACY OFFICE
NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. This notice is effective April 14, 2003. Please review it carefully.

INTRODUCTION

We are required by law to maintain the privacy of "protected health information. "Protected health information" includes any identifiable information that we obtain from you or others that related to your physical or mental health, the health care you have received, or payments for your health care, including premiums paid by you.

As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of protected health information. This notice also discusses the uses and disclosures we will make of your protected health information. We must comply with the provisions of this notice, although we reserve the right to change the terms of this notice from time to time and to make the revised notice effective for all protected health information we maintain. You can always request a copy of our most current privacy notice from the Privacy Office at A PERFECT FIT.

USES AND DISCLOSURES OF MEDICAL INFORMATION

We will refer to your "health information" throughout this Notice. When we say "Health Information," we mean what the federal privacy rules (the HIPAA privacy regulations") called "Protected Health Information." This individually identifiable health information, including demographic information, collected from you or created or received by a health care provider or a health plan and that relates to your past, present, or future physical or mental health or condition, the provision of health care to you, the past, present, or future payment for the provision of health care to you. Any terms not defined in this Notice should have the same meaning as they have in the HIPAA Privacy Regulations as set out in 45 C.F.R. 164.501.

REQUIRED DISCLOSURES OF YOUR HEALTH INFORMATION

We **must** disclose your health information:
-To you or someone who has legal right to act for you (your personal representative), if the information you seek is contained in a designated record set, and
-The Secretary of the Department of Health and Human Service, if necessary, to investigate or determine our compliance with the HIPAA Privacy Regulations.

PERMISSIVE DISCLOSURES OF YOUR HEALTH INFORMATION

We **have the right** to use and disclose your health information for:

Payment: We may use and disclose your health information to determine your eligibility for benefits. We may disclose your health information to a claims administrator to obtain payment or engage in other payment activities.

Health Care Operations: We may use and disclose your health information for health care operations. Health care operations include: *Business planning, development, management, and general administration, including customer service, grievance resolution, de-identifying health information, and creating limited data sets for health care operation, public health activities, and research.

For a full list of the activities covered by the terms in this section, please consult the definitions set out in 45 C.F.R. 164.501.

Others Covered by the Privacy Rule: We may disclose your health information to a health plan or to a health care provider for certain health care operations subject to federal privacy protection laws. We may do so as long as the plan or provider has or had a relationship with you and the health information is for that plan's or provider's health care quality assessment and improvement activities, evaluation or fraud and abuse detection and prevention.

Business Associates: We hire individuals and companies to perform various functions on our behalf to provide certain types of services for us. In order to help us, these business associates may receive, create, maintain, use, or disclose your health information. Before they may have any contact with your health information, we require them to sign a written agreement stating they will keep your health information private and secure.

Examples of our business associates include:
•Insurance Companies/Claims Administrator
•Physician's Office

Your Authorization: You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. However, we will not be able to undo any action that was taken before that authorization was revoked. Unless you give us a written authorization, we will not use or disclose your health information for any purpose other than those described in the Notice.

Family, Friends, and Others Involved in Your Care of Payment for Care: Unless you object, we may disclose your health information to a family member, friend or any other person you involve in your health care or payment for your health care. We will disclose only the health information that is related to the person's involvement. We may use or disclose your name, location, and general condition to notify, or to assist an appropriate public or private agency to locate and notify, a person responsible for your health care in appropriate situations, such as medical emergency or during disaster relief efforts. (For example, to Red Cross during a natural disaster.)

Before we make such a disclosure, we will provide you with an opportunity to object. If you are not present or are incapacitated or it is an emergency or disaster relief situation, we will use our professional judgment to determine whether disclosing your health information is in your best interest under the circumstances.

Health-Related Products and Services: We may use your health information to communicate with you about health- related products, benefits and services and payment for those products, and about treatment alternatives that may be of interest to you.

Public Health and Benefit Activities: Although this does not occur often, we may use and disclose your health information when required by law and when authorized by law for the following kinds of public interest activities:
•For public health, including to report vital statistics;
•To avert a serious and imminent threat to health or safety;
•For health care oversight, such as activities of state insurance commissioners, licensing and peer review authorities, and fraud prevention enforcement agencies;
•For research in certain situations, such as when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the information; approved the research;
•In response to court and administrative orders and other lawful process;
•To law enforcement officials with regard to crime victims, crimes on our premises, crime reporting in emergencies, and identifying or locating suspects or other persons;
•To coroners, medical examiners, and funeral directors.
•To the military, to federal officials for lawful intelligence, counterintelligence, and national security activities, and to correctional institutions and law enforcement regarding persons in lawful custody;
•As authorized by state worker's compensation laws.

INDIVIDUAL RIGHT

The following are your rights with respect to your health information. If you would like to exercise any of the following rights, please submit your request in writing, sign your request, and mail it to A Perfect Fit:

Privacy Office 5001 N. Kings Highway, Suite 101 Myrtle Beach, SC 29577.
Our contact information is provided at the end of this Notice.

Access: You have the right to examine and to receive a copy of your health information we maintain about you in a "designated record set," with limited exceptions.
You are not entitled to inspect and/or copy:
•Any information compiled in anticipation of or for use in any civil, criminal, or administrative action or proceeding;
•Certain other records as specified in the HIPAA Privacy Regulations.
Generally, a "designated record set" contains:
•Claims and payment information;
•Billing information;
•Other records used to make decisions about your health care benefits.
In certain situations we may deny your request to inspect and obtain a copy of your health information. If we deny your request, we will notify you in writing and will inform you whether or not you have the right to have the denial reviewed.

Disclosure Accounting: You have the right to an accounting of certain disclosures that we make of your health information after April 13, 2003, excluding disclosures for treatment, payment, as authorized by you, and for certain other activities.
We will provide you with information about each accountable disclosure that we made during the period for which you request the accounting, except we are not obligated to account for a disclosure that occurred more than six years before the date of your request and never for a disclosure that occurred before April 14, 2003.

Amendment: You have the right to request that we amend your health information that we maintain about you in your designated record set. We may deny your request for certain reasons. For example, we may deny your request, if the information, you want to amend was created by your doctor. If we deny your request, we will provide you a written explanation, and explain to you how you can disagree with the denial by filing a statement of disagreement with us. If we accept your request, we will make your amendment part of your designated record set, and use reasonable efforts to inform others of the amendment who we know may have relied to the unamend information to your detriment, as well as, persons you tell us you want to receive the amendment.

Restriction: You have the right to request that we restrict our use or disclosure of your health information for treatment, payment, or health care operations, or with family, friends, or others you identify. We are not required to agree to your request. If we do agree, we will honor our agreement, except in a medical emergency or as required or authorized by law. Any agreement we may make to request for restriction must be in writing and agreed to by our Privacy Office.

Confidential Communication: If you believe that a disclosure of all or part of your health information may endanger you if sent to your current mailing address, you have the right to request that we communicate with you in confidence about your health information by a different means or to a different location that you specify. You must make your request in writing, and your request must represent that the information could endanger you if it is not communicated in confidence as you request.

We will accommodate your request if it is reasonable. You must specify the alternative means of contact or location for confidential communication. Please note that other information that we send to the insured, if you are a dependent, about health care benefits received may contain sufficient information to reveal that you obtained care, even though you requested that we communicate with about the health care in confidence. If you have given someone else permission to receive health information about you, a request for confidential communications will cancel this permission unless you tell us otherwise.

Electronic Notice: If you received this Notice on our web site or by electronic mail (e-mail), you have the right to receive this Notice in written form. Please contact us using the information at the end of this Notice to obtain this Notice in written form.

Potential Impact of State Privacy Laws: The federal health care Privacy Regulations generally do not "preempt" (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extend state law applies, the privacy laws of South Carolina, or other federal laws, rather than the HIPAA Privacy Regulations, might impose a privacy standard under which we will be required to operate.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us using the information at the end of this Notice.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information, in response to a request you made to amend, restrict the use or disclosure of, or communicate in confidence about your health information, you may complain to us using the contact information at the end of this Notice. You also may submit a written complain to the Secretary of the United States Department of Health and Human Services. We will provide you with the address to file your complaint with the United States Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

CONTACT INFORMATION

<u>Privacy Office</u>

A Perfect Fit
5001 N. Kings Highway, Suite 101
Myrtle Beach, South Carolina 29577   Phone 843-692-2555   Fax 843-692-9976

MEDICARE DMEPOS SUPPLIER STANDARDS

Note: This is an abbreviated version of the supplier standards every Medicare DMEPOS supplier must meet in order to obtain and retain their billing privileges. These standards, in their entirety, are listed in 42 C.F.R. 424.57(c).

1. A supplier must be in compliance with all applicable Federal and State licensure and regulatory requirements.
2. A supplier must provide complete and accurate information on the DMEPOS supplier application. Any changes to this information must be reported to the National Supplier Clearinghouse within 30 days.
3. A supplier must have an authorized individual (whose signature is binding) sign the enrollment application for billing privileges.
4. A supplier must fill orders from its own inventory, or contract with other companies for the purchase of items necessary to fill orders. A supplier may not contract with any entity that is currently excluded from the Medicare program, any State health care programs, or any other Federal procurement or non-procurement programs.
5. A supplier must advise beneficiaries that they may rent or purchase inexpensive or routinely purchased durable medical equipment, and of the purchase option for capped rental equipment.
6. A supplier must notify beneficiaries of warranty coverage and honor all warranties under applicable State law, and repair or replace free of charge Medicare covered items that are under warranty.
7. A supplier must maintain a physical facility on an appropriate site and must maintain a visible sign with posted hours of operation. The location must be accessible to the public and staffed during posted hours of business. The location must be at least 200 square feet and contain space for storing records.
8. A supplier must permit CMS or its agents to conduct on-site inspections to ascertain the supplier's compliance with these standards.
9. A supplier must maintain a primary business telephone listed under the name of the business in a local directory or a toll free number available through directory assistance. The exclusive use of a beeper, answering machine, answering service or cell phone during posted business hours is prohibited.
10. A supplier must have comprehensive liability insurance in the amount of at least $300,000 that covers both the supplier's place of business and all customers and employees of the supplier. If the supplier manufactures its own items, this insurance must also cover product liability and completed operations.
11. A supplier is prohibited from direct solicitation to Medicare beneficiaries. For complete details on this prohibition see 42 CFR § 424.57 (c) (11).
12. A supplier is responsible for delivery of and must instruct beneficiaries on the use of Medicare covered items, and maintain proof of delivery and beneficiary instruction.
13. A supplier must answer questions and respond to complaints of beneficiaries, and maintain documentation of such contacts.
14. A supplier must maintain and replace at no charge or repair cost either directly, or through a service contract with another company, any Medicare-covered items it has rented to beneficiaries.
15. A supplier must accept returns of substandard (less than full quality for the particular item) or unsuitable items (inappropriate for the beneficiary at the time it was fitted and rented or sold) from beneficiaries.
16. A supplier must disclose these standards to each beneficiary it supplies a Medicare-covered item.
17. A supplier must disclose any person having ownership, financial, or control interest in the supplier.
18. A supplier must not convey or reassign a supplier number; i.e., the supplier may not sell or allow another entity to use its Medicare billing number.
19. A supplier must have a complaint resolution protocol established to address beneficiary complaints that relate to these standards. A record of these complaints must be maintained at the physical facility.
20. Complaint records must include: the name, address, telephone number and health insurance claim number of the beneficiary, a summary of the complaint, and any actions taken to resolve it.
21. A supplier must agree to furnish CMS any information required by the Medicare statute and regulations.
22. All suppliers must be accredited by a CMS-approved accreditation organization in order to receive and retain a supplier billing number. The accreditation must indicate the specific products and services, for which the supplier is accredited in order for the supplier to receive payment for those specific products and services (except for certain exempt pharmaceuticals).
23. All suppliers must notify their accreditation organization when a new DMEPOS location is opened.
24. All supplier locations, whether owned or subcontracted, must meet the DMEPOS quality standards and be separately accredited in order to bill Medicare.
25. All suppliers must disclose upon enrollment all products and services, including the addition of new product lines for which they are seeking accreditation.
26. A supplier must meet the surety bond requirements specified in 42 CFR § 424.57 (d).
27. A supplier must obtain oxygen from a state-licensed oxygen supplier.
28. A supplier must maintain ordering and referring documentation consistent with provisions found in 42 CFR § 424.516(f).
29. A supplier is prohibited from sharing a practice location with other Medicare providers and suppliers.
30. A supplier-must remain open to the public for a minimum of 30 hours per week except physicians (as defined in section 1848(j) (3) of the Act) or physical and occupational therapists or a DMEPOS supplier working with custom made orthotics and prosthetics.

MEDICARE DMEPOS SUPPLIER STANDARDS

DMEPOS suppliers have the option to disclose the following statement to satisfy the requirement outlined in Supplier Standard 16 in lieu of providing a copy of the standards to the beneficiary.

The products and/or services provided to you by (supplier legal business name or DBA) are subject to the supplier standards contained in the Federal regulations shown at 42 Code of Federal Regulations Section 424.57(c). These standards concern business professional and operational matters (e.g. honoring warranties and hours of operation). The full text of these standards can be obtained at http://www.ecfr.gov. Upon request we will furnish you a written copy of the standards.