CLIENT PROFILE

Name:_____ SSN:_____ Birthdate:_____

Address:_____ Apt #:_____ City/State/Zip:_____

Phone #1:(____)_____-_____ Phone #2:(____)_____-_____E-mail:_____

Emergency Contact #:(___)_____-_____ Name of Contact:_____Relationship:_____

Employer/School:_____ Full-Time:☐ Part Time:☐ Retired:☐ Not Employed:☐

Primary Insurance Company:_____ ID#:_____ Group#:_____

Name of Primary Insured:_____ D.O.B:_____ SSN:_____ Spouse / Parent

Secondary Insurance Company:_____ ID#:_____ Group#:_____

Marital Status: Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ Special Assistance Req'd:_____

Prescribing Dr.:_____ Hospital:_____ Phone#(____)_____-_____

Please list the dates on which you had a Mastectomy, including which side: _____L/R _____L/R _____L/R
Please list the dates on which you had a Lumpectomy, including which side: _____L/R _____L/R _____L/R
Please list the dates on which you had a Reconstruction, including which side: _____L/R _____L/R _____L/R

If you were BORN with uneven breasts and have NOT had breast surgery, please indicate which side: Left / Right / N/A

Please list fabric allergies:_____Can we contact you regarding your next fitting and receipt of products? Y/N

Would you like to offer your services as a volunteer for BFRIN, a nonprofit organization? Y / N / Not now, but in the future

Fitter:_____

Place of Service:_____

☐Updated Address on File

Weight:_____

Band:_____

Left:_____ Right:_____

Measured Bra Size:_____

Lymphedema Measurements

Palm:_____ Wrist:_____

Elbow:_____ Axilla:_____

Wrist to Axilla:_____

PATIENTS' INITIALS BELOW

Received Care Instructions:_____

Received Warranty Instructions:_____

Reviewed Cost:_____

Reviewed Grants:_____

Contact Card Given:_____

By signing below, you authorize the release to BFRIN of any medical or other information necessary to process medical claims. BFRIN has your consent to discuss confidential matters to your Emergency Contact. You also request payment of medical benefits to be rendered to BFRIN as a supplier of Durable Medical Equipment. Your health insurance company might dispense a check made payable to you covering the cost of the products/services you received from BFRIN. By signing below, you agree to immediately forward such monies to BFRIN. This document serves as an Assignment of Benefits. Failure to remit monies from your insurance company/grantors will result in adverse action. You have the right to freely voice grievances and recommend changes in care or services without fear of reprisal or unreasonable interruption of care. Service, equipment, and billing complaints will be communicated to management and upper management, progressively and up to the President of the organization. All complaints will be handled in a professional manner, investigated, acted upon and responded to in writing or via telephone within a reasonable amount of time after the receipt of the complaint. We value the person that you are and the journey that you are on. We will do our best to care for you!

X_____ _____

Signature Today's Date

Health Insurance Portability and Accountability Act of 1996 (HIPAA) & Medicare DMEPOS Supplier Standards Notice

How We Collect Information About You: BFRIN collects data through a variety of means including but not necessarily limited to letters, phone calls, emails, voice mails, and from the submission of applications that are either required by law or other requests for assistance through our organization.
What We Do Not Do With Your Information: Information about your financial situation, medical condition and care that you provide to us in writing, via email, telephone and voicemail, contained in or attached to applications, or directly or indirectly given to us, is held in strictest confidence. We do not give out, exchange, barter, rent, sell, lend, or disseminate any information about applicants, patients or clients who apply for and/or actually receive our services that is considered patient confidential, restricted by law, or has been specifically restricted by a patient/client in a signed HIPAA consent form.
How We Do Use Your Information: Information is only used as is reasonably necessary to process your claim or to provide you with health related services which may require communication between BFRIN and health care providers, medical product or service providers, insurance companies, your emergency contact person listed on file and others necessary to: verify that your medical information is accurate and determine the type of medical supplies and/or healthcare services you need. If you apply or attempt to apply for assistance through us and provide information with the intent or purpose of fraud or that which results in either an actual crime of fraud for any reason including willful or unwillful acts of negligence whether intended or not, or in any way demonstrates or indicates attempted fraud, your non-medical information or any other information as permitted by law can be given by us to legal authorities including police / court officials, investigators, and legal professionals as necessary.
Limited Right to Use Non-Identifying Personal Information From Biographies, Letters, Notes, and Other Sources: Any pictures, stories, letters, biographies, correspondence, or thank you notes sent to us becomes the exclusive property of BFRIN. We reserve the right to use non-identifying information about our clients/patients for fundraising and promotional purposes that are directly related to our mission. You will not be compensated for use of this information and no identifying information (photos, addresses, phone numbers, contact information, last names or uniquely identifiable names) will be used without your express advance permission. You may specifically request that NO information be used whatsoever for promotional purposes, but you must identify any requested restrictions in writing. We respect your right to privacy and assure you that no identifying information or photos you send to us will ever be publicly used without your direct consent. By signing below, you indicate that you understand your rights to privacy regarding your protected health information. These rights are given to you under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). By signing this consent you authorize BFRIN to use and disclose your protected health information to obtain payment from third party payers (i.e. your insurance company, grantors, etc.); as well as perform the day-to-day healthcare operations of BFRIN's practice. I understand that I have the right to review and secure a copy of this statement. I understand that BFRIN reserves the right to change the terms of this notice from time to time and that you may contact BFRIN at any time to obtain the most current copy of this notice. You understand that you have the right to request (in writing) restrictions on how your protected health information is used and disclosed to carry out treatment, payment and health care operations, but that BFRIN is not required to agree to these requested restrictions. However, if agreement is made, BFRIN is then bound to comply with such restriction. You understand that you may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date you revoke this consent is not affected by such revocation.

MEDICARE DMEPOS SUPPLIER STANDARDS: The products and/or services provided to you by BFRIN 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://ecfr.gpoaccess.gov. Upon request we will furnish you a written copy of the standards.

X _____ _____

Signature Today's Date

_____ _____

Printed Name DOB

08312023

☐ PRODUCT RECEIPT / ☐ PACKING SLIP

					Type of Item Color Size Brand Style # Qty Items Needed (Listed Below):
Notes:					Patient's Home Address / Delivery Address

Fitter:_____ Chestwall Moulded?_____ Nipple Moulded?_____ Scanned?_____

Bill for Fitting/Training/Office Visit?_____ Authorization Required if Dollar Amount is Exceeded?_____ Need Left/Right Modifier?_____

Primary Insurance Company:_____ ID#:_____

Primary Insured's Name (if other than patient):_____ Primary Insured's Date of Birth:_____

Prescribing Dr's Name:_____ NPI #:_____

Prior Authorization #:_____ LEFT / RIGHT / BILATERAL MASTECTOMY / LUMPECTOMY / ANOMALLY

The above-mentioned supplies have been delivered to me (or an agent assigned by me) and meet my expectations. BFRIN has informed me that I may either rent or purchase inexpensive or routinely purchased durable medical equipment if I so desire. I have also received a warranty and written instructions on how to use and care for all dispensed items safely and effectively. I have been given a copy of the Medicare DMEPOS Supplier Standards or informed that I can receive a copy at http://ecfr.gpoaccess.gov.

Signature:X _____ Today's Date:_____ Patient's Name:_____ D.O.B.:_____

Representative's Name:_____

PATIENT MEDICAL RECORDS RELEASE

Patient's Full Name:_____ Birthdate:_____ Telephone #:(____)_____-_____

Address:_____ Apt #:_____ City/State/Zip:_____

I hereby authorize BFRIN to Release/Request ALL Private Health Information (PHI)* contained in my medical records

or if any items are circled below, only these items are authorized by me to be released to BFRIN:

Lab Reports X-Ray Reports

Sexual Abuse Information Sexually Transmitted Diseases (STD's)

Drug and Alcohol Abuse Information Child Abuse and Neglect Reports

Psychiatric Information HIV/Aids Report

Other (please specify):

*Note: While specific confidential PHI will not be included, the information authorized for release may make reference to confidential findings.

Release of PHI is for a medical and/or health related purpose.

I understand that I may revoke this authorization in writing at any time except to the extent that the release has been made prior to my revocation in reliance on this authorization and that such release shall not constitute a breach of my right to confidentiality. Unless I otherwise revoke this authorization in writing, it is valid. I understand that by releasing PHI, my PHI might be subject to re-disclosure. I hereby release BFRIN from any legal responsibility or liability regarding PHI discussed in this Release. I have read this authorization and fully agree to its contents.

X_____ _____

Signature of Patient, Parent or Representative Today's Date

_____ _____

If signed above by a parent, legal guardian, power of attorney or other legal signatory, please state persons name

08312023

_____

Signer's relationship to patient

ADVANCE BENEFICIARY NOTICE OF NON-COVERAGE (ABN)

NOTE: If the policy you have with your insurance company, Medicare and/or Medicaid does not pay for any portion of the items listed below, you may have to pay. Your policy does not always pay for everything, even some care that you or your health care provider have good reason to think you need. Your policy may not pay for the items listed below along with their associated costs (per unit):

_____Surgical Bra ($60)
_____Silicone Prosthesis ($450)
_____Lymphedema Sleeve ($200)
_____Prosthetic Fitting ($240)
_____Consultation ($200)
_____Post Surgical Camisole ($80)
_____Custom Breast Prosthesis ($4,000)
_____Cranial Prosthesis / Wig ($500)
_____Prosthetic Nipple ($40)
_____Other_____($)
_____Foam Prosthesis ($300)
_____Lymphedema Glove/Guauntlet ($150)
_____Prosthetic Training ($240)
_____Prosthesis Cover ($50)
_____Other_____($)

Some of the reasons that your policy might not pay the full amount of our claim is that 1) You have reached the maximum number of units for these items; 2) You have not met your annual deductible; 3) These items are not covered under your plan; 4) Another reason as mandated by your policy.

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading this notice.
- Choose an option below about whether to receive the items listed above.

OPTIONS

Option 1. I want the items listed above. You may ask to be paid now, but I also want Medicare, Medicaid and or my insurance company billed for an official decision on payment, which is sent to me on a Medicare Summary Notice or EOB. I understand that if my policy does not pay, I am responsible for payment, but I can appeal to Medicare and/or my insurance company by calling their Member Service telephone number or by following the directions on the MSN. If my policy does pay, you will refund any payments I made to you, less co-pays or deductibles.

Option 2. I want the items listed above, but do not bill Medicare and/or my insurance company. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare and/or my insurance is not billed.

Option 3. I don't want the items listed above. I understand with this choice, I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

This notice gives our opinion, not an official Medicare nor other Insurance Company's decision. If you have other questions on this this notice orMedicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048). If you do not have Medicare coverage, please contact your health insurance company. Signing below means that you have received and understand this notice. You also receive a copy.

Signature:_____ Date:_____ Patient Name:_____ D.O.B._____

Primary Insurance Co:_____ Insurance ID #:_____ Secondary Insurance Co.:_____ Insurance ID #:_____