

# 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#: \_\_\_\_\_

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

Please list fabric allergies: \_\_\_\_\_ Can we contact you regarding your next fitting and receipt of products? Yes/No

Would you like to offer your services as a volunteer for BFRIN, a nonprofit organization? Yes / No / Not now, but in the future.

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 and/or grantor 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. BFRIN has the right to refuse service any person who poses a threat, causes abuse or undue stress, whether physical or verbal or otherwise, to any of its volunteers, employees, patients and other associates. 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!

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: \_\_\_\_\_

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 an 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

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Signature

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Today's Date

-----  
Printed Name

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DOB



# 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

\_\_\_\_\_  
Signer's relationship to patient

# ADVANCE BENEFICIARY NOTICE OF NON-COVERAGE (ABN)

NOTE: If the policy you have with your insurance company and/or Medicare does not pay for any portion of the items listed below, you may have to pay Out-of-Pocket. 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)	_____ Post Surgical Camisole (\$80)	_____ Foam Breast Prosthesis (\$400)
_____ Silicone Breast Prosthesis (\$450)	_____ Custom Breast Prosthesis (\$4,000)	_____ Lymphedema Glove/Gauntlet (\$150)
_____ Lymphedema Sleeve (\$200)	_____ Cranial Prosthesis / Wig (\$5,000)	_____ Prosthetic Training (\$240)
_____ Prosthetic Fitting (\$240)	_____ Prosthetic Nipple (\$40)	_____ Prosthesis Cover (\$50)
_____ Consultation (\$200)	_____ Custom Fabricated Prosthetic Nipple (\$5,000)	_____ 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. If no option is chosen, Option 1 will be chosen for you.

## 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 or Medicare 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 can also request a copy.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Patient Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Primary Insurance Co: \_\_\_\_\_ Insurance ID #: \_\_\_\_\_ Secondary Insurance Co.: \_\_\_\_\_ Insurance ID #: \_\_\_\_\_