



# NEW PATIENT INFORMATION

Return this form to: [Submitforms@axiobionics.com](mailto:Submitforms@axiobionics.com)

## PATIENT INFORMATION

Patient's First Name		M.I.	Last Name		Date of Birth
Street Address		City		State	Zip Code
				Gender <input type="checkbox"/> M <input type="checkbox"/> F	
Phone 1	Phone 2	Email			Marital Status <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D

## EMERGENCY/GUARDIAN CONTACT INFORMATION

<b>Contact 1</b> First Name	M.I.	Last Name	Relationship to Patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Guardian
Phone		Email	
<b>Contact 2</b> First Name	M.I.	Last Name	Relationship to Patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Guardian
Phone		Email	

## PRIMARY INSURANCE INFORMATION *(required)*

Name of Insurance Company			Insurance Phone
Member ID #	Group #		Plan #
Insured's Name <i>(if not the patient)</i>		Insured's Date of Birth	Relationship to Patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Guardian
Adjuster's Name	Phone	Email	Fax
Nurse/Case Manager's Name	Phone	Email	Fax

## SECONDARY INSURANCE INFORMATION *(complete this section if you have additional insurance coverage)*

Name of Insurance Company			Insurance Phone
Member ID #	Group #		Plan #
Insured's Name <i>(if not the patient)</i>		Insured's Date of Birth	Relationship to Patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Guardian
Adjuster's Name	Phone	Email	Fax
Nurse/Case Manager's Name	Phone	Email	Fax

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## OTHER INSURANCE INFORMATION *(complete this section if you have additional insurance coverage)*

Name of Insurance Company		Insurance Phone	
Member ID #	Group #	Plan #	
Insured's Name <i>(if not the patient)</i>		Insured's Date of Birth	Relationship to Patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Guardian
Adjuster's Name	Phone	Email	Fax
Nurse/Case Manager's Name	Phone	Email	Fax

## IF NOT INSURED

Self Pay: <input type="checkbox"/> Credit Card <input type="checkbox"/> Payment Plan <input type="checkbox"/> Check <input type="checkbox"/> Other:
---

## HEALTH CARE PROVIDERS

List all health care providers including physicians, specialists, clinicians, physical and occupational therapists, prosthetists and othotists so we may contact them to obtain patient's medical background/history and any other information that will help us process your claim.

<b>Name 1</b>	Specialty	Clinic
Address	Phone	Fax
<b>Name 2</b>	Specialty	Clinic
Address	Phone	Fax
<b>Name 3</b>	Specialty	Clinic
Address	Phone	Fax
<b>Name 4</b>	Specialty	Clinic
Address	Phone	Fax
<b>Name 5</b>	Specialty	Clinic
Address	Phone	Fax
<b>Name 6</b>	Specialty	Clinic
Address	Phone	Fax

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INJURY ILLNESS INFORMATION

Type of Illness/Injury		
<input type="checkbox"/> Chronic Pain	<input type="checkbox"/> Stroke	<input type="checkbox"/> Muscular Dystrophy
<input type="checkbox"/> Spinal Cord Injury	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> ALS
<input type="checkbox"/> Traumatic Brain Injury	<input type="checkbox"/> Brachial Plexus Injury	<input type="checkbox"/> Other:
<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Hemispherectomy	_____
Date of Injury or Onset of Illness/Symptoms	Is Injury/Illness the Result of an Accident? (select all that apply)	State Where Accident Occurred
	<input type="checkbox"/> Work-related <input type="checkbox"/> Auto <input type="checkbox"/> Other:	

EMPLOYMENT INFORMATION (fill out only if injury/illness was work-related)

Name of Employer	Employment Status
	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> Student <input type="checkbox"/> Other

DEVICE INFORMATION

What type of AxioBionics Device are you interested in?	Where did you hear about us?
<input type="checkbox"/> Wearable Therapy® <input type="checkbox"/> WalkAide®/Pace FES	<input type="checkbox"/> Website (Web Search)
<input type="checkbox"/> TripleFlex™ <input type="checkbox"/> Orthotics	<input type="checkbox"/> Doctor <input type="checkbox"/> Facebook
	<input type="checkbox"/> Therapist <input type="checkbox"/> Twitter
	<input type="checkbox"/> Orthotist/Prosthetist <input type="checkbox"/> Other:

EXISTING MEDICAL CONDITIONS

Cancer	<input type="checkbox"/> YES <input type="checkbox"/> NO	Heart Condition	<input type="checkbox"/> YES <input type="checkbox"/> NO
In remission?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Cardiac Demand Pacemaker	<input type="checkbox"/> YES <input type="checkbox"/> NO
Seizure Disorder	<input type="checkbox"/> YES <input type="checkbox"/> NO	Manufacturer:	Model:
On Anti-seizure Medications?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Phone:	
Seizures under control?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Cardiac Defibrillator	<input type="checkbox"/> YES <input type="checkbox"/> NO
Brain Impairments	<input type="checkbox"/> YES <input type="checkbox"/> NO	Manufacturer:	Model:
Varicose Veins	<input type="checkbox"/> YES <input type="checkbox"/> NO	Phone:	
Allergies to Adhesives	<input type="checkbox"/> YES <input type="checkbox"/> NO	Metal Implants in the body	<input type="checkbox"/> YES <input type="checkbox"/> NO
Blood Clots	<input type="checkbox"/> YES <input type="checkbox"/> NO	Location:	
Diabetes	<input type="checkbox"/> YES <input type="checkbox"/> NO	Other Medical Conditions	<input type="checkbox"/> YES <input type="checkbox"/> NO

Describe all conditions for which you checked YES, and any others not listed:


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**PRIMARY INSURANCE INFORMATION**

I authorize AxioBionics to release any medical or other information about me to my other healthcare providers or any other party for the purposes of treatment, payment, or healthcare operations; to my insurance company, health benefit plan, federal health benefits program, third-party payer, third-party administrator, or any other party, including any billing and/or collection service utilized by AxioBionics, necessary to process an insurance claim and/or to invoice and collect payment for items/services provided by AxioBionics and to release any medical or other information about me to auditors authorized by AxioBionics for the purpose of certification, licensure and accreditation, audit and/or review. I permit a copy of this authorization to be used in place of the original. I further authorize AxioBionics to contact me via telephone regarding services to be provided to me.

**ASSIGNMENT OF INSURANCE BENEFITS**

I certify that the information given by me is correct. I request that payment for authorized benefits are made on my behalf, I assign the benefits payable for covered services rendered by AxioBionics and authorize AxioBionics to submit claims to Medicare, Medicaid and/or commercial insurance carries, other third-party payers, and administrators for payment. I authorize payment of my benefits directly to AxioBionics.

**PAYMENT POLICY AND RESPONSIBILITY FOR PAYMENT**

I understand that it is my responsibility to know my insurance benefits and coverage for all durable medical equipment, supplies and services provided to me by AxioBionics. I understand that AxioBionics, as a courtesy to me, will make every reasonable effort to bill all of my insurance companies for payment of my account. I understand that my insurance does not pay for everything and may not pay for the services or products (including durable medical equipment supplies) provided by AxioBionics. I understand that any remaining balance is my responsibility. I further agree to be personally and fully responsible for all items and services provided by AxioBionics that my insurance will not pay for and any deductibles and/or co-payments to the fullest extent allowed by law and my health benefits plan. If AxioBionics determines that insurance coverage is not available, I understand I that am responsible for all costs.

In the event that I fail to make a payment for which I am personally liable within thirty (30) days after invoice from AxioBionics, I understand that AxioBionics will charge interest on the outstanding balance at the rate of 1.5% per month until the outstanding balance is paid in full. I understand that payment may be made by cash, check, Visa, MasterCard, or American Express and I am responsible for making payment arrangements with AxioBionics if payment cannot be made in full upon receipt of the invoice. I further agree that in the event that any account is placed with an outside collection agency due to nonpayment, I will be responsible for any collection fees that may be added to my outstanding balance. I also understand that a \$135.00 office visit charge will be added to my account should I decide to cancel a service/device after casts, molds, or measurements have been made. I agree to pay this charge in the event it is incurred.

I understand that the products made by AxioBionics are custom-made or custom-fit and include a significant degree of professional service that render the products non-returnable. I understand that all sales are final and no refunds will be issued for any reason. Fitting devices such as prosthetics, orthotics, and neuroprosthetic devices to the human body may require making adjustments on an individual basis to ensure proper fit, maximize benefit and function, and ensure safety of use. AxioBionics is committed to this process and, as such, adjustments to fit and performance are included in the AxioBionics one-year warranty.

**PATIENT ACKNOWLEDGEMENTS**

1. I certify that I have received a copy of the AxioBionics Privacy Practices.
2. I am aware that I have a condition which requires orthotic and/or prosthetic treatment by AxioBionics. I understand that my physician has ordered this item/service as part of my treatment and that I am under his/her supervision.
3. I am also aware and acknowledge that representatives of AxioBionics have made no guarantees to me regarding the results of any examination or treatment.
4. I understand that multiple visits may be required to achieve proper fit and/or desired results.
5. I have read this authorization form, or it has been read to me, and I understand its contents and agree to its terms.
6. I have completed this form fully and accurately, and have been given the opportunity to ask questions about this form and the services and products that may be provided.
7. I am competent and able to make decisions concerning the services and products that may be provided.

Patient's Signature	Print Name	Date
Authorized Representative's Signature	Print Name	Date
Authorized Representative's Relationship to Patient:		



**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our office at 800-552-3539.

By signing this form, you acknowledge receipt of the Notice of Privacy Practices of AxioBionics.

\_\_\_\_\_  
Please print your name here

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

**AUTHORIZATION TO OBTAIN MEDICAL HISTORY**

By signing below, I give permission for AxioBionics to access my medical history. This consent will enable AxioBionics to:

1. Process medical billing to your insurance company or other third party payer (in paper format).
2. Communicate with your primary care physician or other medical specialists to obtain the necessary medical information to manage your case.
3. Place orders on your behalf for items and products from other vendors and specialists.
4. Communicate with your attorney, our attorney, or other legal representatives in order to adjudicate your claim.

In summary, we ask your permission to obtain medical information to properly care for you and to bill for AxioBionics products and services.

\_\_\_\_\_  
Please print your name here

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

Effective Date of this Notice: February 14, 2019



AxioBionics  
6111 Jackson Rd., Suite 200  
Ann Arbor, MI 48103  
Phone 800-552-3539 • FAX 888-574-6888

**NOTICE OF PRIVACY PRACTICES**

As Required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Your medical information is personal and AxioBionics is committed to protecting your privacy. We are obligated by law to protect your privacy and give you notice of our privacy practices. This Notice describes how we protect your protected health information and what rights you have regarding your protected health information. "Protected health information" (PHI) means any of your written and oral health information, including demographic data that can be used to identify you. AxioBionics will abide by and act in accordance with the terms of this Notice. Additionally, AxioBionics will notify you if there has been a breach of your unsecured protected health information. If you have any questions, please contact AxioBionics' Privacy Officer at 800-552-3539.

We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment will be effective for all of your protected health information that AxioBionics has created or maintained and for any generated in the future. AxioBionics will have copies of our current Notice in our office and this will also be posted on our website, you may request a paper copy of our most current Notice at any time.

**HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION**

The following categories describe the ways in which we may use and disclose your protected health information. AxioBionics may use your protected health information for purposes of providing treatment, obtaining payment for treatment, and conducting health care operations. Your protected health information may be used or disclosed only for these purposes unless AxioBionics has obtained your authorization or the use or disclosure is otherwise permitted by the HIPAA Privacy Regulations. For clarification, we have included some examples. Not every possibility is specifically mentioned. However, all of the ways we are permitted to use and disclose your protected health information will fit within one of these general categories.

**TREATMENT**

AxioBionics may use and disclose your medical information to treat you. Common reasons for use and disclosure may include performing exams, ordering or performing tests, referring you to other medical professionals, or obtaining copies of information from other health care providers to facilitate your treatment.

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## PAYMENT

AxioBionics may use and disclose your protected health information in order to bill and collect payment for services. We may disclose your protected health information to a health care plan to determine eligibility or plan responsibilities for benefits, confirm enrollment and coverage, facilitate payment for treatment and covered services received, coordinate benefits with other insurance carriers, and adjudicate benefit claims and appeals.

## HEALTH CARE OPERATIONS

AxioBionics may use or disclose your health information to conduct our business. This may involve disclosures of information for quality assessment and improvement activities, data aggregation services, care coordination, and case management. Other examples include business planning and administrative activities. We will not sell any of your health information unless we have received your express written authorization.

## **OTHER DISCLOSURES SPECIFIED BY HIPAA WHICH DO NOT REQUIRE YOUR AUTHORIZATION**

### DISCLOSURES REQUIRED BY LAW

AxioBionics will use and disclose your protected health information when we are required to do so by federal, state or local law. For example, disclosure may be required by Workers' Compensation statutes and various public health statutes in connection with required reporting of births and deaths, certain diseases, child abuse and neglect, domestic violence, adverse drug reactions, etc.

### HEALTH OVERSIGHT ACTIVITIES

AxioBionics may disclose your protected health information to a health oversight agency for activities authorized by law. Oversight activities can include investigations, inspections, audits, surveys, licensure, and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws, and the health care system in general.

### LAWSUITS AND SIMILAR PROCEEDINGS

If you are involved in a lawsuit or similar proceeding, we may use and disclose your protected health information in response to an order of a court or administrative order or in response to a signed authorization.

### LAW ENFORCEMENT AND/OR NATIONAL SECURITY

We may disclose your protected health information for law enforcement purposes. For example, in limited circumstances we may disclose your protected health information if you are a victim of a crime. We may provide information about a crime at AxioBionics, or to report a crime that happened elsewhere. Additionally, we may disclose your protected health information for the purpose of identifying or locating a suspect, material witness or missing person. Further, we may disclose your protected health information to federal officials for intelligence and national security activities authorized by law including to protect the President or other officials including foreign heads of state, to conduct investigations, or for military purposes.

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#### DECEASED PATIENTS

AxioBionics may release protected health information to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs or, when requested, to facilitate organ, eye or tissue donation.

#### RESEARCH

Under certain circumstances, we may use and disclose your protected health information for health related research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another for the same condition.

#### SERIOUS THREATS TO HEALTH OR SAFETY

AxioBionics may use and disclose your protected health information to prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

### **USES AND DISCLOSURES PERMITTED WITHOUT AUTHORIZATION BUT WITH OPPORTUNITY TO OBJECT**

#### COMMUNICATION WITH FAMILY

Occasionally, our staff may discuss particular diseases and their inheritance patterns with you or your family members, if you agree.

Other uses and disclosures of your protected health information not covered by this Notice will be made only with your written authorization. If you provide us with such an authorization, you may revoke it, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your information for the reasons covered by the authorization.

### **YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION**

You have the following rights with respect to your protected health information:

#### CONFIDENTIAL COMMUNICATIONS

You have the right to request confidential communications from us. Upon receiving a reasonable written request from you for confidential communications we will communicate your protected health information by an alternative method or to an alternative location.

#### RIGHT TO OPT OUT

You have a right to opt out of receiving any fund raising notices from AxioBionics.

#### REQUESTING RESTRICTIONS

You have the right to request a restriction in our use or disclosure of your protected health information for the purposes of treatment (except in emergencies or when required by law), payment or health care operations. We are not required to agree to your request except as described below; if we do agree, we

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are bound by our agreement except in cases of an emergency or in cases where we are legally required or allowed to make a use or disclosure. We are obligated to comply with a request to restrict disclosure to a health plan if the disclosure is for the purposes of carrying out payment or health care operations and is not otherwise required by law and you have paid AxioBionics in full for the services AxioBionics has provided. To request a restriction on the disclosure of your protected health information you must make your request in writing to the Privacy Officer listed on page one.

### INSPECTION AND COPIES

You have a right to request a copy of your protected health information. You must submit your request in writing to the Privacy Officer listed on page one. AxioBionics may charge a reasonable fee for the costs of copying and mailing your information.

### AMENDMENT

If you feel that protected health information we have about you is incorrect or incomplete, you may send us a written request to amend the information. The request must include a reason supporting your request and should be sent to the Privacy Officer listed on page one. We may deny your request if you ask us to amend information that is, in our opinion, accurate and complete, not part of the information kept by us, not part of the protected health information which you would be permitted to see and copy, or if it was not created by us.

### LIST OF DISCLOSURES

You have the right to request an accounting of disclosures AxioBionics has made of your protected health information for non-treatment, non-payment or non-operations purposes. Use of your protected health information by AxioBionics for purposes of treatment, payment or operations is not required to be documented and, therefore, will not be on the list. Further, the list will not include disclosures made with your authorization, incidental disclosures or those required by law. In order to obtain a list of disclosures, you must submit your request in writing to the Privacy Officer listed on page one. All requests for disclosures must identify a time period (not to exceed six years) and may not include dates before April 14, 2003. You are entitled to one such list per year free of charge; additional accounting requests may be subject to a reasonable cost based fee.

### RIGHT TO NOTICE

You have the right to receive notice and AxioBionics will notify you if there has been a breach of your unsecured protected health information.

### RIGHT TO A PAPER COPY OF THIS NOTICE

You are entitled to receive additional copies of this notice of privacy practices at any time. To obtain a copy of this notice, write to the Privacy Officer listed on page one of this notice.

### RIGHT TO FILE A COMPLAINT

If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer for AxioBionics or with the Secretary of the Department of Health and Human Services. To file a complaint with AxioBionics, write to the Privacy Officer listed on page one. AxioBionics will not retaliate against you in any way for submitting a complaint.

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## APPEALS AUTHORIZATION

I, \_\_\_\_\_ (patient/guardian), grant AxioBionics, LLC authorization from this day forward to represent me in the appeals process with my insurance company or any third-party entity for any denial received for AxioBionics products and services.

_____	_____	_____
Authorized Representative (print)	Signature	Date
_____	_____	_____
Patient Name (print)	Signature	Date
_____		
Street Address		
_____	_____	_____
City	State	Zip Code
Country: <input type="checkbox"/> United States	_____	
	Country	
_____	_____	
Email	Phone	