BFrin
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# 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

**THIS BOX - OFFICE USE ONLY**

Fitter:_____

Place of Service:_____

Weight:_____

Band:_____

Left:_____ Right:_____

Measured Bra Size:_____

Lymphedema Measurements

Palm:_____ Wrist:_____

Elbow:_____ Axilla:_____

Wrist to Axilla:_____

Updated Address on File:_____

Reviewed Care:_____

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

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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 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, my 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 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, I indicate that I understand my rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize BFRIN to use and disclose my protected health information to obtain payment from third party payers (i.e. my 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 I may contact BFRIN at any time to obtain the most current copy of this notice. I understand that I have the right to request (in writing) restrictions on how my 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 this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I 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

# ☐ PRODUCT RECEIPT / ☐ PACKING SLIP

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

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

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*The aforementioned 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. BFRIN has also provided instructions on how to use items safely and effectively.*

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

Representative's Name:_____ 04222019

# PATIENT MEDICAL RECORDS RELEASE

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

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

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

_____ All PHI including confidential information _____ All PHI excluding the items indicated below:

| | | | |
|---|---|---|---|
| | 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 _____ Attorney _____Physician _____Insurance _____Other/Please Specify:_____

Mail or fax to: BFRIN / 7176 Marshall Road / Upper Darby, PA 19082 / Phone: 866-473-3325 Fax: 866-473-3325 (same as phone)

*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. Treatment of payment may not be conditioned on obtaining authorization for release of PHI. 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

_____ _____

Witness Signature / Witness Name - Printed Today's Date

# ADVANCE BENEFICIARY NOTICE OF NON-COVERAGE (ABN)

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

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 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 also receive a copy.

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

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

# PATIENT EXPECTATIONS FOR CUSTOM BREAST PROSTHESIS

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Please review the following statements with your fitter so that she can determine whether or not this is the best time to be molded for your prosthesis:

| | |
|---|---|
| I am undergoing radiation or chemotherapy. | Yes / No |
| It has been 6 months since I finished radiation and chemotherapy. | Yes / No |
| I have broken skin on my chest wall or underarm. | Yes / No |
| I have hypersensitivity or painful areas on my chest wall or underarm. | Yes / No |
| I am on a diet or exercise plan to lose or gain weight. | Yes / No |
| I am taking a steroid. | |

_____ * I understand the prosthesis is made to be worn against the chest wall and not in the pocket of a mastectomy bra.

_____ * I understand the prosthesis was designed to fit best in the bra I was scanned/molded in. This is the bra style I wear most often.

_____ * I understand if I wear the prosthesis in a bra different than the style of bra I was scanned/molded in, I may not achieve an optimal fit.

_____ * I understand that the BFRIN Custom Breast Prosthesis comes in select colors. The color I choose will be close to the color swatch, but not exact.

_____ * I understand skin tones can change through the course of a season; therefore, I should not try to match a suntan.

_____ * I understand actual breast size can vary during the menstrual cycle or due to weight gain or loss; if I lose/gain weight, the prosthesis may not fit properly.

_____ * I understand there is no guarantee on the location, amount, etc. of requested freckles and veins.

_____ * I understand there may be a fill hole on the back of the prosthesis and additional holes throughout the prosthesis to allow ventilation.

_____ * Proper fit and wear of the prosthesis does not require adhesion to the chest wall. I understand that adhering the prosthesis is optional and not guaranteed.

_____ * I have discussed with the fitter, the area of my surgical site that I want filled-in/covered and how that relates to whether or not I want the prosthesis to show outside of the bra.

_____ *(For Unilateral Patients ONLY) I understand the prosthesis will look like my remaining breast as it appears in a bra.

_____ *(For Bilateral Patients ONLY) I understand that the prostheses will look like the shape and size of the breast forms and bra that I am scanned/molded in.

_____ * I understand the prosthesis has a one year warranty against manufacturing defects. Tears in the foam core are expected and are not a manufacturing defect.

_____ * I understand that my prosthesis will be unique in shape and size; therefore, it will look different from the sample.

_____ * The above expectations have been explained to me and I understand them completely.

X_____ _____ _____ _____

Patient's Signature | Today's Date | Patient's Name | DOB

***Thank you for letting us care for your custom breast prosthesis needs. It is our pleasure to serve you!***

04222019