A Fitting Experience Mastectomy Shoppe, Inc.

2950 North State Road 7 #103 Margate, Florida 33063 (954) 978-8287 (800) 419-5475

WWW.AFITTINGEXPERIENCE.COM

Store Policy & Consent Form Agreement

CONSENT/AUTHORIZATION FOR SERVICE: I authorize **A FITTING EXPERIENCE MASTECTOMY SHOPPE, INC.** under the direction of a prescribing Physician, to provide after breast surgery supplies and services.
ASSIGNMENT OF BENEFITS/AUTHORIZATION FOR PAYMENT: I hereby assign all benefits and payments to be made directly to **A FITTING EXPERIENCE MASTECTOMY SHOPPE, INC.** for any after breast surgery products, supplies and services furnished to me. I authorize **A FITTING EXPERIENCE MASTECTOMY SHOPPE, INC.** to seek such benefits and payments on my behalf. It is understood that as a courtesy, our staff will verify benefits and will bill Medicare, your HMO, PPO, and other payors and insurer(s) providing coverage. A FITTING EXPERIENCE will not guarantee your insurance benefits or "wipe-off" deductible balances or copayments. I understand that I am responsible for providing all necessary information and for making sure all certification and enrollment requirements are fulfilled. Any changes in the policy must be reported to **A FITTING EXPERIENCE MASTECTOMY SHOPPE, INC.** within 30 days of the event. I have been informed by **A FITTING EXPERIENCE** of the medical necessity for the services prescribed by my Physician. **MEDICARE BENEFICIARIES ONLY**: If applicable, I have been notified prior to my fitting of the ADVANCED BENEFICIARY NOTICE OF NON-COVERAGE (ABN). Payment for products on **MEDICARE NON-ASSIGNED CLAIMS** is expected at the time of service. Beneficiary will be reimbursed directly from Medicare/Supplement. **PLEASE INTIAL:**_____

GRIEVANCE REPORTING: I acknowledge that I may lodge a complaint without concern for reprisal, discrimination, or unreasonable interruption of service. To place a grievance, please call: **(954) 978-8287** and speak with facility manager on duty. If your complaint is not resolved to your satisfaction within five (5) business days, you may initiate a formal grievance in writing and forward it to:
A Fitting Experience 2950 N. State Rd. 7 Suite #103 Margate, Florida 33063 ATTN.: GOVERNING BODY

Thank You for choosing A FITTING EXPERIENCE MASTECTOMY SHOPPE, INC. as your specialty provider. We are honored by your choice and are committed to providing you with the highest quality products and services. We look forward to establishing a lasting relationship. As part of this relationship, we have outlined our expectation for your financial responsibility. Please read this document thoroughly and if you have any questions, please feel free to contact our office staff at (954) 978-8287.

- **YOUR RESPONSIBILITY begins when you call to make an appointment. Please know your insurance. Be aware of what they pay for and do not pay for, as well as any co-pay and deductibles.**
- **COPAYMENTS AND DEDUCTIBLES: Co-pays are collected at the time of check-in. Insurance deductibles and fees for services not covered by your insurance policy, if known, are due at the time the service and merchandise is rendered. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your portion due. We accept Cash, Check, and most major credit cards.**
- **.UNPAID BALANCES: Unpaid balances are ultimately the responsibility of the insured.**
- **APPOINTMENT CANCELLATION POLICY: In most cases, our Staff works diligently works to obtain Referrals, Authorizations, Prescriptions and Medical Records on your behalf. Should you need to cancel your appointment, a new scheduled appointment must be made within 10 business days or a $25.00 Fee will be charged/billed directly to you.**

CLIENT PATIENT HANDOUTS **I acknowledge that I have been made available a copy of each:**

- ***SUPPLIER STANDARDS-Full text of standards may be found at: http://ecfr.gpoaccess.gov**
- **HIPAA PRIVACY STANDARDS**
- **PATIENT RIGHTS AND RESPONSIBILITIES**
- **CARE/USE/PRODUCT WARRANTY COVERAGE**

DATE OF SERVICE: _____/_____/_____ CFm:_____License #_____

Signature

REV. 01/2018©-PC.5.1&PS.9.2

TURN FORM OVER TO OTHER SIDE

➢ **PRODUCT SAFETY:** **1.) Your new products meet the specifications of your current prescription/referral.**
2.) Have been checked for structural safety.
3.) All manufacturer guidelines are followed.

EMERGENCY & PERMISSION TO CONTACT: Our staff may need to reach you to update records, for follow up of your last Date of Service and/or to schedule appointments.

☐ **YES** **A FITTING EXPERIENCE** staff **may** contact me in order to update my records by:
PHONE AND MAY LEAVE A MESSAGE ON MY ANSWERING MACHINE. I may be contacted via E-MAIL, OR U.S. MAIL concerning the furnishing of Medicare covered items to be supplied and/or regarding appointments and other relevant issues. The information may be shared in person; by phone; email.

☐ **DO NOT LEAVE A MESSAGE ON MY ANSWERING MACHINE.** I may **NOT** be contacted via E-MAIL, OR U.S. MAIL concerning the furnishing of Medicare covered items.

I, authorize A FITTING EXPERIENCE MASTECTOMY SHOPPE, INC. to share information, when necessary, with:

FULL NAME	RELATIONSHIP	PHONE NUMBER

☐ **DO NOT RELEASE MY PRODUCTS ON HOLD FOR PICK UP TO ANYONE BUT MYSELF.**

If you cannot reach us during our regular business hours, please call (954) 978-8287 and leave a message. We will return your call by the end of the next business day.

I have read and understand the Store Policy, Financial Responsibility and Permission to Contact: PLEASE PRINT NAME AND SIGNATURE BELOW.

PLEASE PRINT NAME:_____

X_____
Signature of Insured/Authorized Representative **(Relationship to Insured)**

DATE OF SERVICE: _____/_____/_____

SUPPLIER STANDARDS:

The products and/or services provided to you by A FITTING EXPERIENCE MASTECTOMY SHOPPE, INC. are subject to the Supplier Standards contained in the Federal regulation shown at 42 Code of Federal Regulations Section 424.57(c). These standards concern post-mastectomy products suppliers and operational matters. The full text of these standards can be obtained at **http://ecfr.gpoaccess.gov**. We will furnish you a written copy of these standards upon request.

DATE OF SERVICE: _____/_____/_____ CFm:_____License #_____
Signature

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