5307 South 92nd Street, Ste 127 • Hales Corners, WI 53130
ph: 414.235.8552 • fax: 262.922.4402 • www.xceedmedical.com
email: info@xceedmedical.com

Patient Agreement Form

CSR_____

REQUIRED INFORMATION **Surgery Date** ____/____/____ **Patient Discharge Date** ____/____/____

☐ **Not Applied in Hospital** ☐ **SNF Discharge Date** ____/____/____

PATIENT INFORMATION ☐ **Female** ☐ **Male**

Full Name _____

Street Address _____

City, State, Zip _____

HM # _____ Cell # _____

DOB _____ SSN # _____

Employer _____

Emergency Contact Name & Ph # _____

PRESCRIPTION FORM **Date** _____

Dr. Name (last) _____

(First) _____ (M.I.) _____ ☐ M.D. ☐ D.P.M. ☐ D.O

Address _____

City _____ State _____ Zip _____

Phone (_____) _____ NPI#_____

Physician Signature _____

No Stamps - Original Signature Only!

ICD-10 CODE _____, _____, _____, _____

Date of Injury _____

Length of Need ☐ 1-3 months ☐ 3-6 months ☐ +6 months

Reason for Need/ Medical Necessity

☐ Increased Functional Activity ☐ Fortify Joint Stability ☐ Reduce Swelling

Advanced Notice of Non-coverage (Patient Initials_____)

I have been informed the products provided to me may not be covered by insurance due to one of the following reasons:

Benefits yet to be determined, not medically necessary by my insurance plan, experimental or investigational, or excluded under my benefits allowance (non-covered)

INSURANCE INFORMATION (Attach or Fill Out)

Insurance Name_____ ☐ **Primary** ☐ **Secondary**

ID # _____GR #_____

Insurance Company Ph# (_____)_____

Cardholder Name _____DOB_____

Insurance Name _____ ☐ **Primary** ☐ **Secondary**

ID # _____ GR # _____

Insurance Company Ph# (_____)_____

Cardholder Name _____DOB_____

☐ **WORK COMP or AUTO** Claim # _____

Adjuster/Contact _____

Authorized Contact # _____

PATIENT SPECIFIC SERVICE PLAN PHYSICIAN ORDERS

☐ Orthotic Brace ☐ Bone Growth Stimulator

☐ Knee ☐ Shoulder ☐ Wrist ☐ Elbow ☐ Hand ☐ Neck ☐ Spine

☐ Left ☐ Right ☐ Bilateral

PROOF OF DELIVERY

Please provide bar code, label or complete info. ☐ Right ☐ Left QTY_____

SIZE _____

INSTRUCTIONS (Person taught if other than patient)_____

(*Check box*) ☐ **Patient Knows & Understands:**

- Bill of Rights
- Device Operation
- Device Settings
- When to Contact Physician
- Complaint Process
- How to Reach Xceed Med. with Questions or Problems

(*Check box*) ☐ **These Have Been Verified:**

- Proper Electrical
- Hand Controller Accessible
- Patient Instructions Provided
- Patient / Caregiver Demostrates Competency
- Switches Operable
- Cord(s) Unobstructed
- Device Working in Home
- Proper Patient Kit Application
- Secure Device Placement
- Infectious Control Info.

Estimated Copay/Co-Ins _____

Credit Card # _____

Exp. _____ **SEC Code #** _____

FINANCIAL RESPONSIBILITY

I understand that I am responsible for co-insurance, deductible and non-covered aounts determined by my insurance plan. I agree to allow Xceed Medical to utilize my credit card info for any unpaid balance of the above charges. I understand that I will be notified of all charges prior to the use of my credit card. I have read and agree to the terms and conditions stated above.

ACKNOWLEDGEMENTS

By signing below I acknowledge that I have received the above product and understand my Patient Bill of Rights and Responsibilities and that I understand how to properly operate the device. I also agree to allow Xceed Medical to use my Protected Health Info. for Health Care Operations including payment of claims, obtaining information from my designated health care provider and for quality assurance/improvement. If I choose not to allow Xceed Medical to release my PHI, I will responsible for payment of all products and services I have received Xceed Medical release of my protected health information will terminate wheh my account balance with Xceed Medical is zero dollars for more than 60 days. A full explanation of Xceed Privacy Practices can be found on the Patient Information Booklet. I may receive auto-dialed, pre-recorded calls, or both from, or on behalf of (clients name) at the telephone or wireless number(s) provided above. I consent to receiving future calls at those number(s) by autodialed calls, pre-recorded calls, or both, and understand that my consent to such calls in not a condition of purchasing any goods or services.
I was hereby given advance notice that Medicare does not pay for cold therapy products, slings, rib belts, flexible back braces, post-op shoes, cast boots, insoles/shoe inserts, heel cups, wedges/pads, arh supports, elbow protectors, elastic supports, surgical stockings, and spinal brace soft interface obtained from Xceed Medical. I understand that because these items are excluded from Medicare coverage I am responsible for payment to Xceed. If I am renting CPM equipment, I understand that Medicare will only cover CPM treatment for total knee replacement. Use of device must commence within two days following surgery and is limited to the three week period following surgery during which the device is used in my home. I acknowledge I have received the following information as applicable: Medicare Supplier Standards, Notice of Privacy Practices, Patient Rights & Responsibilities, Complaint Reporting Information to TCT@888-291-5353, and Warranty Infomation.

I have been instructed and understand the written instruction how to use and maintenace of the product I received.

Patient or Authorized Rep. Signature _____ Date _____

Relationship to Patient & Reason Patient Cannot Sign _____

Authorized Reps. Address _____ Ph# _____