Patient Registration

Georgia Carolina Orthotic Centers
Wrightsboro Road Augusta, Ga 30904
706.496.3911

Patient Name: _____ _____ _____ **Gender: (M / F)**
First M.I. Last

Date of Birth: _____ **Age:** _____ **Height:**_____ **Weight:** _____

Address: _____ **City:** _____ **State:** _____ **Zip**_____

Primary Phone #: _____ **Alternate Phone #:** _____

Email Address: _____ **May we leave a message? (Y or N)**

Primary Care Doctor: _____ **Podiatrist:** _____

Primary Insurance Company: _____ **I D#:** _____**Group #/Name:** _____

Secondary Insurance Company: _____ **I D#:** _____**Group #/Name:** _____

Emergency Contact: _____
First and last name Relationship Phone Number

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I have been given a copy of **Georgia Carolina Orthotic Centers(GCOC)** Notice of Privacy Practices and understand these rights. I also understand that it is my responsibility to notify **GCOC** in writing of any restrictions to my patient file.

OFFICE PROCEDURES

I hereby give consent to **GCOC** to provide treatment and service the Provider may deem necessary.
I understand that I am responsible for payment of charges and that payment is due at the time of service, or I hereby assign insurance benefits to be paid directly to **GCOC** for professional fees.
I hereby consent and authorize **GCOC** to file medical claims for treatment, electronically or manually, to my insurance carrier(s) for services rendered to me.
I understand that I am responsible for charges not covered by my insurance policy.
I understand that I am responsible for a fee of $25.00 for any returned check.

RELEASE OF CONFIDENTIAL INFORMATION & AUTHORIZATION

I hereby permit a copy of this authorization to be used in place of any original signed document. I understand that this original will be placed in my patient file to be kept at the **GCOC** office.
I hereby consent and grant permission for Practitioners employed by **GCOC** to discuss my medical treatment for orthotics with my referring physician, primary care physician, physical therapist, occupational therapist, hospital and/or rehabilitation staff, relating to my care and treatment.
I understand that this is a Lifetime Release of Information unless I have placed restrictions in my patient file and have completed the necessary forms.
In addition, I hereby consent for **GCOC** to discuss my medical treatment with the following:

_____ _____
Name **Relationship** **Name** **Relationship**

I have read, understand, and agree to all the above.

_____ _____ _____
Patient's Signature Patient's Printed Name Date Signed

_____ _____ _____
Representative's Signature Representative's Printed Name Date Signed

2301 Wrightsboro Road
Augusta, Georgia 30904
Phone 706.496.3911
706.496.2148

IMPORTANT MEDICARE DOCUMENTATION INSTRUCTIONS

Providing this benefit for your patient is as easy as

One, Two, Three...

One

Complete the **Statement of Certifying Physician** Confirming the patient meets Medicare's criteria that they have diabetes and one of the six qualifying conditions listed on the Statement.

Two

Complete the **Prescription for Diabetic Shoes and Inserts,** along with any special instructions.
(Unless one was provided by the patients DPM)

Three

Provide a copy of your **Patient Notes** with the sections showing:
1) diagnosis of the qualifying conditions
and
2) treatment of the patient's diabetes.
(Please see detailed explanation below)

Return these three documents to the patient or simply fax them to the provider listed at the top of this brochure. If you have any questions, please contact the provider for assistance.

Dear Primary Care Doctor,

Thank you for helping your patient receive Diabetic Footwear. Medicare has for years required you to complete and submit the Statement of Certifying Physician. However, in June of 2010, Medicare revised policy requirements for coverage.

NOW, WE MUST HAVE CLINICAL NOTES FROM YOU THAT SUPPORT THE FOUR MAJOR PORTIONS OF THE STATEMENT OF CERTIFYING PHYSICIAN. IF THE CLINICAL NOTES DO NOT SUPPORT THE STATEMENT OF CERTIFYING PHYSICAN, THE STATEMENT IS RENDERED VOID.

CLINICAL NOTES GUIDELINES

1. Must document that the patient has diabetes and assign a valid and supported ICD-1O code. Results of tests, exams, findings must be in the notes (i.e. blood glucose levels and A1c), not merely the ICD-10, although the ICD-10 is also required.

2. Must document that they are treating the patient under a comprehensive plan of care for his/her diabetes. The doctor should elaborate other portions of the plan of care (medicine, nutrition, education, other specialists).

3. Must document that the patient needs diabetic shoes to protect their feet.

4. Must document a foot exam and one or more of the required conditions. This includes the details of tests, exams, inspections, findings, etc. that were used to come to the conclusion that the condition exists. You may rely on information from the medical records of other doctors (i.e. foot doctor), but must obtain, initial, date, and indicate agreement with them:

- **History of partial or complete amputation of the foot**
- **History of previous foot ulceration**
- **History of pre-ulcerative callus**
- **Peripheral neuropathy with evidence of callus formation**
- **Foot deformity**
- **Poor circulation**

We understand these requirements place a burden on you and your staff. Thank you for your assistance.

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Shoes and Insert Prescription

Patient Name:_____ DOB:_____

Address: _____ Phone: _____

Medicare ID: _____ Date of last Visit: _____

Diagnosis Code/s: _____

1. Type of shoes prescribed (check/circle):
   - ○ Extra Depth (A5500) 1 pair or L or R
   - ○ Custom Molded (A5501) 1 pair or L or R
2. Types of inserts prescribed (check/circle):
   - ○ Heat Moldable (A5512) 1 pair 2 pairs 3 pairs
   - ○ Custom Fabricated (A5513) 1 pair 2 pairs 3 pairs

Right	Left	
○	○	Rocker Bottom - per shoe
○	○	Wedge - per shoe
○	○	Metatarsal Bar - per shoe
○	○	Off Set Heel - per shoe
○	○	Toe Filler (L5000) - per shoe

3. Custom fabricated functional arch support (non covered Medicare)

Right	Left	
○	○	Custom Arch Support (L3020)

Prescribing Physicians Name:_____ NPI: _____

Address: _____

Phone:_____ Fax: _____

Physician Signature:_____ Date: _____

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Therapeutic Shoes for Persons with Diabetes Statement of Certifying Physician

Patient Information:

Last name:_____First name:_____MI: ____

DOB (MM/DD/YYYY):_____Gender: __ M __ F __ Other Medicare ID:_____

I certify that all of the following statements are true:

1. This patient has diabetes mellitus
2. This patient has one or more of the following conditions (check all that apply)

_____History of partial or complete amputation of the foot

_____History of previous foot ulceration

_____History of pre-ulcerative calli

_____Peripheral neuropathy with evidence of callus formation

_____Foot deformity

_____Poor circulation

3. I am treating this patient under a comprehensive plan for his/her diabetes.
4. This patient needs special shoes (depth or custom-molded shoes) because of his/her diabetes.

Signature, name, date, and NPI (must be an M.D. or D.O.)

Signature_____Date(MM/DD/YYYY):_____

Name (Printed): _____NPI_____

Address:_____

City:_____State:_____Zip:____