



**NewportCare<sup>®</sup>**  
**MEDICAL GROUP**  
 3300 WEST COAST HIGHWAY  
 NEWPORT BEACH, CA 92663

**PATIENT INFORMATION  
 FOR MEDICAL RECORDS**

Today's Date \_\_\_\_\_

**Patient Name** \_\_\_\_\_

Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Social Security No. \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip Code \_\_\_\_\_ Telephone No. \_\_\_\_\_

Occupation \_\_\_\_\_ Driver's License No. \_\_\_\_\_

Employer-Name \_\_\_\_\_ Employer Telephone No. \_\_\_\_\_

Employer Address \_\_\_\_\_

Married       Single       Divorced       Widow

**EMAIL ADDRESS:** \_\_\_\_\_

**Spouse/or Responsible Parent** \_\_\_\_\_

Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Social Security No. \_\_\_\_\_

Address \_\_\_\_\_ Telephone No. \_\_\_\_\_

Occupation \_\_\_\_\_ Driver's License No. \_\_\_\_\_

Employer-Name \_\_\_\_\_ Employer Telephone No. \_\_\_\_\_

Employer Address \_\_\_\_\_

**Emergency Contact(Other than husband or wife) person not living with you**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

- Please Complete if patient is under 21 years of age or a student

Father's Name \_\_\_\_\_ Mother's Name \_\_\_\_\_

Father's Occupation \_\_\_\_\_ Mother's Occupation \_\_\_\_\_

Father's Employer \_\_\_\_\_ Mother's Employer \_\_\_\_\_

Address \_\_\_\_\_ Address \_\_\_\_\_

**Medical Insurance Information**

Primary Insurance Subscriber \_\_\_\_\_ Secondary Insurance Subscriber \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Insurance Co. \_\_\_\_\_

Identification No. \_\_\_\_\_ Identification No. \_\_\_\_\_

Group No. \_\_\_\_\_ Group No. \_\_\_\_\_



# Physician Order Rx/Request for Authorization: Prescription Form/ Certificate of Medical Necessity

Patient Name \_\_\_\_\_ Physician Name \_\_\_\_\_

Surgery Center \_\_\_\_\_ Primary ICD-9 Code(s) \_\_\_\_\_ DOI: \_\_\_\_\_  Right  Left

Product Description  Place Sticker Here
---

Product Description  Place Sticker Here
---

Product Description  Place Sticker Here
---

### Narrative Report:

My signature below acknowledges that, in my judgment, the prescribed item is medically indicated & necessary and consistent with current accepted standards of medical practice and treatment of this patients physical condition. My signature also serves to confirm the veracity of all information included in this document.

**Products:**  Compression Stocking  Walker Boot  Post-Op Shoe  Knee Immobilizer  Post-Op Knee  
 LSO  Abdominal Binder  Sling  Shoulder Immobilizer  Cervical Collar  Wrist Brace  Crutches  
 Thumb Spica  Front Wheel Walker  Other \_\_\_\_\_

### Pneumatic Intermittent Compression (PIC) Device with bilateral calf wraps

TAKE HOME PORTABLE DEVICE

*Place Label With Serial # Here*

**DEVICE:** Pneumatic Intermittent Compression Device - Duration 1-30 Days  
**APPLIANCE(S):** Segmental Gradient Pressure Pneumatic Appliance(s) X2 - Duration 1-30 Days  
**MEDICAL COMPLICATIONS:**  CVI  Diabets  DVT  Lymphedema  Other: \_\_\_\_\_

**Narrative Report:** In my evaluation of this patient. I have noted there is a higher risk of developing Deep Venous Thrombosis (DVT), due to the type of surgery performed combined with other risk factors. I am Prescribing DVT Prophylaxis involving the use of a pneumatic compression device and the necessary appliances. This patient will have decreased ability and duration of ambulation following surgery, which will significantly increase the risk factors associated with DVT, Pulmonary Embolism (PE), DVT and PE can be major complications associated with these surgeries, resulting in significant morbidity and mortality rates, as stated by the American College of Chest Physicians.

Significant published data is available on the incidents of DVT/PE, the effectiveness of various prophylactic techniques and the risks of hemorrhage when heparin is used, all of which provide positive and compelling evidence in support for the use of intermittent compression devices in DVT prevention. The plantar and lower leg wraps have added the advantage of reproducing the physiological mechanism of venous return. Impaired venous blood flow in post abdominal/orthopedic surgeries, trauma, and other conditions that impede or significantly decrease ambulation of patients most certainly will decrease circulation which can result in edema, pain, delayed healing and increased risk of DVT and PE. The clinical trials show clear evidence that these complications and risk factors can be significantly minimized with the use of the PIC devices.

For these reasons, PIC device and compression wraps are prescribed for this patient to maximize the most positive outcome of surgery and minimize the potential for serious complications. I have successfully used this device in my practice and my patients tolerate the treatment protocol with a very high degree of compliance. I feel this protocol is the most beneficial and cost effective treatment of my patients in greatly reducing the development of DVT, which when ignored can result in significant increase in morbidity and mortality and increased utilization of health care resources and dollars.

### Rental to Purchase Option

NewportCare Medical Group makes every effort to provide you with equipment that is yours to keep. However, from time to time your doctor may prescribe a rental piece of equipment such as T.E.N.S. If you need a T.E.N.S. prescribed by your doctor, you may know your insurance may help pay for it. T.E.N.S. are normally rented on a monthly basis. If you wish to purchase the T.E.N.S. because you may need it for extended use, we will apply any daily rental rates to the purchase price. In making your decision to rent or purchase this equipment, you should know that you will be responsible for 20% of the service charge. If you choose the purchase option, you will be responsible for the purchase amount less than the rental.

**Option**  
 Rental  
 Purchase

### Patient Acknowledgment & Authorization to Assignment of Benefits(PA/AOB)

I acknowledge receiving instruction, have demonstrated or verbalized my understanding in the proper use and care of the equipment or supplies received today described on this document & will follow them. I understand company business hours and a NewportCare Medical Group representative will be contacting me regarding my financial responsibilities related to this agreement. I acknowledge receipt & understand the Company Patient Information Privacy Notice and that all information on this document is correct. I understand and agree that I am responsible for payment or products and services provided by NewportCare Medical Group. I agree to make payment, in full, upon receipt of payment from insurance company to policy holder if not endorsed and forwarded to NewportCare Medical Group. I authorize release of any medical information necessary to process this claim and certify the above information is correct. I authorize any and all payments of medical benefits to NewportCare Medical Group for the products and services rendered.

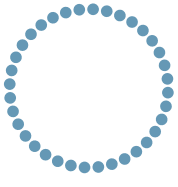
Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Product Delivery Acknowledgment (Required for Medicare Claims)

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

License# \_\_\_\_\_ NPI# \_\_\_\_\_ Physician Signature \_\_\_\_\_

Patient Sticker Here



**NewportCare<sup>®</sup>**  
**MEDICAL GROUP**  
3300 WEST COAST HIGHWAY  
NEWPORT BEACH, CA 92663

## **PATIENT CONSENT FORM**

I understand that, under the Health Insurance Portability and Accountability Act of 1966 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used for the following:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations, such as quality assessments and physician certifications.

Only upon request you organization will provide a copy of Notice of Privacy Practices containing a more detailed description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at this address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are required to agree to my requests, and by agreeing to such requests: you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on the consent.

---

**Patient Name(Print)**

---

**Signature**

---

**Relationship to Patient**

---

**Date**



**NewportCare<sup>®</sup>**  
**MEDICAL GROUP**  
 3300 WEST COAST HIGHWAY  
 NEWPORT BEACH, CA 92663

**RELEASE OF RECORDS**

I \_\_\_\_\_, hereby give NewportCare Medical Group authorization to discuss my medical condition and test results with:

Please list all the names and phone numbers as appropriate.

Spouse \_\_\_\_\_

Mother \_\_\_\_\_

Father \_\_\_\_\_

Sister(s) \_\_\_\_\_

Brothers(s) \_\_\_\_\_

Son(s) \_\_\_\_\_

Daughter(s) \_\_\_\_\_

Caregiver \_\_\_\_\_

Answering machine at phone number \_\_\_\_\_

Other \_\_\_\_\_

No one but patient \_\_\_\_\_

\_\_\_\_\_  
**Patient Name(Print)**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Relationship to Patient**

\_\_\_\_\_  
**Date**



**NewportCare<sup>®</sup>**

**MEDICAL GROUP**

3300 WEST COAST HIGHWAY  
NEWPORT BEACH, CA 92663

## **ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

The practice reserves the right to modify the privacy practices outlined in this notice.

I have received a copy of the Notice of Privacy Practices

**Patient Name(Print)** \_\_\_\_\_

**Signature** \_\_\_\_\_

**Relationship to Patient** \_\_\_\_\_

**Date** \_\_\_\_\_

## **DOCUMENTATION OF ATTEMPT TO OBTAIN ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES**

Attempt to Obtain Acknowledgment

An attempt was made to obtain an acknowledgment of Notice of Privacy Practices on

The Acknowledgment was not obtained because:

\*The patient was undergoing emergency treatment

\*The patient declined to sign the Acknowledgment

\*Other \_\_\_\_\_

**Patient Name(Print)** \_\_\_\_\_

**Signature** \_\_\_\_\_

**Relationship to Patient** \_\_\_\_\_

**Date** \_\_\_\_\_



**NewportCare<sup>®</sup>**  
**MEDICAL GROUP**  
3300 WEST COAST HIGHWAY  
NEWPORT BEACH, CA 92663

## **FINANCIAL INTEREST CONSENT**

I, \_\_\_\_\_ (patient), acknowledge and accept that my physician(s) may have financial interest in hospitals, surgery centers, imaging centers, physical therapy and/or surgical devices that he/she chooses to utilize. I hereby recognize my rights to choose another physician or request the services of another facility or device be used.

---

**Patient Name(Print)**

---

**Signature**

---

**Relationship to Patient**

---

**Date**



**NewportCare<sup>®</sup>**  
**MEDICAL GROUP**  
3300 WEST COAST HIGHWAY  
NEWPORT BEACH, CA 92663

## **NEWPORTCARE MEDICAL GROUP OFFICE FINANCIAL POLICY**

Thank you for choosing NewportCare Medical Group. We are committed to the success of your treatment. We hope you understand that payment of your bills is considered part of your treatment. The following is a statement of our financial policy, which we require you read, agree to and sign, prior to any treatment. This financial policy applies to all services rendered by the doctors and physical therapists.

It is our policy that the patient, rather than the insurance company, is responsible for complete payment of our charges. All patients with insurance coverage are required to pay for non-covered services, any deductible amount not previously met and any copay amount due, at the time of services rendered. For patients with dual insurance coverage we will bill both the primary and secondary insurance if you have provided us with the necessary information.

Patients insured with plans which we are NOT contracted with will be required to pay for the first visit in full. For any follow-up visits you will need to pay 30% at the time services are rendered. There will be a 30% down payment prior to any surgery needed.

If you are insured with a plan which we ARE contracted with (including Medicare), you will need to pay for any non-covered services, any outstanding deductible and your copy amount, at the time of each visit. If for any reason the insurance company failed to pay, the patient will be responsible for the entire balance.

Patients with no insurance coverage are expected to pay for the services at the time services are rendered.

Failure to make payment arrangements, or pay outstanding balances within 60 days of notification of amount due, may result in termination of care from NewportCare Medical Group

Our accepted methods of payments are cash, check, Visa, MasterCard or Discover Card. If requested, a short payment schedule may be arranged for those patients who have special financial conditions.

Again, thank you for trusting us with your care. If you have any questions regarding financial responsibility of payment options, please contact our insurance department.

**“I have read, understand and agree to the provisions of this policy”**

---

**Patient Name(Print)**

---

**Patient Signature / Guarantor**

---

**Date**



