

AGREEMENT OF DELIVERY



PATIENT NAME: _____ DATE: _____

DELIVERY LOCATION: _____ DELIVERY DATE: _____

PROCEDURE PROVIDED: _____

PATIENT SIGNATURE: _____

THERAPIST NAME: _____

COMMENTS: _____

PATIENT DATA CONSENT & RELEASE FORM



Three-dimensional (3-D) surface scanning has been used medically, in industry and in the military for over 10 years collecting thousands of scans on hundreds of subjects without incident. The Cyberware surface scanner uses a low level laser source to produce the light that scans the surface of the head. This device is sold commercially and has undergone all the necessary safety checks with human subjects. It simply takes a 3D picture your head and face in less than 15 seconds. There are no medical risks associated with the scanning system.

Total Contact may use your image data to further the use of non-contact surface scanning toward the rehabilitation of burn patients. Your confidentiality associated with your image data will be protected. Your name will not be identified with your scan data. If the data are published in scientific literature, it will be done so without identifying individual subjects. If you decide release your data for Total Contact to use in future research projects, you are free to withdraw your consent without prejudice to your relations with Total Contact, Inc.

I _____ am agreeing to release my data because I want to. The decision to release my data is completely voluntary on my part. No one has coerced or intimidated me into participating in this program. My therapist has answered any and all questions I have asked about this scan, my participation, and the procedures involved, which are set forth above, which I have read. I understand that my therapist will be available to answer my questions concerning procedures throughout this process. I understand that I may withdraw this consent at any time.

PATIENT NAME (PRINT)

DATE

PATIENT SIGNATURE (or Guardian if Patient is under 18)

Relationship to Patient



TOTAL CONTACT PATIENT INFORMATION

PATIENT NAME: _____ DATE: _____
Last First Middle Initial

STREET ADDRESS: _____ APT. NUMBER _____

CITY: _____ STATE: _____ ZIP: _____

PHONE NUMBER: (____) _____ BIRTHDATE: _____ SEX: (F)____ (M)____

SOC. SEC. #: _____ - _____ - _____ MARITAL STATUS: (S)____ (M)____ (D)____ (W)____

PRESCRIBING PHYSICIAN: _____ PRIMARY CARE PHYSICIAN: _____

EMPLOYER: _____

EMPLOYER'S PHONE NUMBER: (____) _____ OCCUPATION: _____

INSURANCE #1 (PRIMARY)

PRIMARY INSURANCE COMPANY: _____ NAME OF INSURED: _____

EMPLOYER OF INSURED: _____ INSURANCE ID NO: _____

POLICY NO: _____ PLAN NO: _____ GROUP NO: _____

RELATIONSHIP TO PATIENT: SELF____ SPOUSE____ CHILD____ INSURANCE PHONE NUMBER: (____) _____

INSURANCE CLAIMS ADDRESS: _____ C CITY: _____ STATE: _____

ZIP: _____ SOC. SEC. # OF INSURED: _____ - _____ - _____ BIRTHDATE OF INSURED: _____

INSURANCE #2 (SECONDARY)

SECONDARY INSURANCE COMPANY: _____ NAME OF INSURED: _____

EMPLOYER OF INSURED: _____ INSURANCE ID NO: _____

POLICY NO: _____ PLAN NO: _____ GROUP NO: _____

RELATIONSHIP TO PATIENT: SELF____ SPOUSE____ CHILD____ INSURANCE PHONE NUMBER: (____) _____

INSURANCE CLAIMS ADDRESS: _____ C CITY: _____ STATE: _____

ZIP: _____ SOC. SEC. # OF INSURED: _____ - _____ - _____ BIRTHDATE OF INSURED: _____

PATIENT'S CONDITION RELATED TO: AUTO ACCIDENT?____ EMPLOYMENT ?____ OTHER ACCIDENT?____

DATE OF ACCIDENT: _____ WORKER'S COMPENSATION NUMBER: _____

CLAIM # _____ EMPLOYER AT TIME OF INJURY _____

I declare under penalty of perjury that the above information is true and correct.

PATIENT NAME (PRINT)

DATE

PATIENT SIGNATURE (or Guardian if Patient is under 18)

Relationship to Patient

PAYMENT POLICY AND YOUR INSURANCE



Will Total Contact help me with my insurance billing?

Yes. In the event you have medical coverage we will assist you in obtaining payment for these services. We will bill your insurance company directly.

What portion of my bill will insurance pay?

Your insurance contract defines to what extent the company will make payment. You are responsible for knowing the limitations of your policy. You will be responsible for any deductible and coinsurance you may have.

Will Total Contact wait for my insurance company to pay?

Yes, if you are prompt with payment of your portion of the bill. We will allow 60 days after filing for insurance settlement. The bill then becomes your responsibility. Although you are responsible for your entire bill, we want to help you receive every insurance benefit to which you are entitled.

Will I receive a statement on the status of the bill?

Yes, you will receive a monthly statement for any open items. We ask you to give prompt attention to our bill. Regular monthly payments are necessary to keep your account current.

The cost of the mask is \$2,200. Total Contact will answer any questions you have related to the fit or cost of the mask or neck splint. Please feel free to call us at (937) 855-6107.

We have prepared this explanation to help you understand our terms for payment or services rendered. Should you have any questions, please do not hesitate to contact Total Contact.

- By signing this agreement, I authorize the release of any medical or other information necessary to process this claim. I acknowledge that I have read this statement and I am financially responsible for the costs associated with the Total Contact orthotics/prosthetics.

PATIENT SIGNATURE DATE Relationship to Patient
(or Guardian if Patient is under 18)

- I hereby authorize payment of benefits, both basic and major medical, directly to the provider for services rendered. In the event that my insurance carrier should pay me directly, I will forward the payment to Total Contact, Inc.

PATIENT SIGNATURE DATE Relationship to Patient
(or Guardian if Patient is under 18)

INDIVIDUAL RESPONSIBLE FOR PAYMENT

NAME _____ ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE NUMBER: _____ SOC. SEC. #: _____ - _____ - _____

NEXT OF KIN

NAME _____ ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE NUMBER: _____ SOC. SEC. #: _____ - _____ - _____