Thank you for choosing Pectus Services to assist in your child’s pectus care. As a courtesy to our patients, we will contact your insurance company to verify your benefits, and submit your claim. The following will need to be sent to our Business Office prior to your first appointment. Please scan the items listed below (preferred method and most clear), take photos (with your cell phone) of your insurance cards and driver’s license.

After gathering the items listed below please SCAN and EMAIL them to the following email address:

   Info@PectusServices.com

They can also be faxed to: 973-488-7185; lastly mail paper copies to the Business Office.

Here is the checklist of items needed:

- **Insurance Card** - front and back
- **Name of the Primary** insured on the policy & their date of birth
- **Driver License** of the Primary Insured / Guarantor
- **Prescription** from your for the brace. Please ask your doctor if they would specify “T-Joe Pectus Brace” on the prescription this may help with getting the brace approved. Please note we can’t brace your child without this.
- **Clinical Notes** from doctors that were seen in relation to the pectus, also x-ray reports, MRI or CT Scans and reports as well.
- **Letter of Medical Necessity** many insurance companies will only cover the brace if it is deemed "Medically Necessary." We encourage you to speak about writing a ‘Letter of Medical Necessity’. It should discuss your child’s symptoms, such as shortness of breath or breathing difficulty, pain, fatigue with exercise, uneven shoulders and any other postural problems. Any of your doctor’s notes should also be included to help with the approval process. Without symptomology your claim has a higher chance of being denied.
- The following forms will also need to be completed and available on our website or may be sent to you by email:

  **Pectus Patient Information Profile; Medical Records Release; Photo Model Release, Consent Form, Financial Agreement, HIPPAA, Assignment of Benefits**

If your insurance company requires pre-authorization (about 25%) and you choose to go ahead with bracing prior to the pre-authorization your insurance company may deny your claim. You can also submit your claim on your own for reimbursement.

We look forward to seeing you at your appointment. Please feel free to contact the Business Office anytime questions.
Pectus Patient Information Profile

Today's Date: _____ / _____ / 20_______

Month   Day             Year

Form of Pectus:  excavatum / carinatum / combination / flared ribs / unsure

Patient Name: ___________________________________________ male / female

First       Middle    Last

Address: _________________________________________________________________

City: ___________________________________________ State: _________ Zip: _________

Home Phone: (____)______________________ Cell: (____)________________________

Current Age: _______ Date of Birth: _____/_____/_________

Current School Grade: ________________     Dominant Hand: Left / Right

Height: ___________ Weight: ___________     Glasses or Contacts: Yes / No

Hobbies / Activities / Interests: _______________________________________________

Sports played (if any): _______________________________________________________

Primary/Best sport: ____________________________ Position(s): __________________

Any previous injuries/illness/surgery and date: ___________________________________

Medical conditions: _________________________________________________________

Medications: none ______________________ Allergies: none_______________________

- continued –
Heart Murmur: Yes / No      Heart Problems: none ________________________________
Pectus Tests done and date: none X-Ray: ___/___/____  CT / MRI Scan: ___/___/____
EKG: ___/___/____  Echocardiogram: ___/___/____  PFT(breathing): ___/___/____

Any family medical history; brothers or sisters with pectus or marfan’s etc.?  Yes / No
-If yes please explain: ___________________________________________________________________

What age did you first notice the Pectus defect?: ________________________________

Is the Pectus defect getting worse?  Yes / No / Stayed the same
-If Yes over what amount of time have you noticed it getting worse?:

6 months  1 year  2 years  Other amount of time: ________________________________

Reason for seeking pectus help and symptoms experienced: (check all that apply)

__Breathing difficulty    __Easily winded
__Chest pain             __Self esteem
__Avoid sports           __Flared ribs
__Asthma-like symptoms  __Avoid swimming
__Avoid changing in gym  __Never show bare chest
__Scoliosis              __Slumped shoulders
__Round / bulging belly  __Forward lurched head
__Wear clothes to hide it __Swayback / curve in low back
__ Uneven shoulders      __Embarrassed by chest

--To help with the pectus assessment, please attach any photos that may show the timeline of the pectus development and dates such as vacation or beach photos and their date.

- continued -
Family Information

Mother

Mother / Step / Guardian’s Name: ________________________________________________

Marital status: Married Single Divorced Separated Widowed

Date of Birth: _____ / _____ / __________

__ Check here if address & phone are same as patient. If not, complete below:

Address: ________________________________________________________________

City: __________________________ State: ______ Zip: __________

Home Phone #: (___)_____________________ Cell #: (___)_____________________

Email: ___________________________________________________________________

Employer: ________________________________ Occupation:_____________________

Father

Father / Step / Guardian’s Name: ________________________________________________

Marital status: Married Single Divorced Separated Widowed

Date of Birth: _____ / _____ / __________

__ Check here if address & phone are same as patient. If not, complete below:

Address: ________________________________________________________________

City: __________________________ State: ______ Zip: __________

Home Phone #: (___)_____________________ Cell #: (___)_____________________

Email: ___________________________________________________________________

Employer: ________________________________ Occupation:___________________

- continued -
Other contacts:

1. Name: _________________________________________________________________
   Relationship: _____________________________ Phone #: (____)___________________

2. Name: _________________________________________________________________
   Relationship: ______________________________ Phone #: (____)__________________

Guarantor’s Information
(Financially Responsible Person)

__ Check here if Guarantor’s information is same as above. If not, complete below:

Guarantor’s Name: ___________________________________________________________

Guarantor’s Relationship to patient:      Parent / Step-Parent / Guardian

Address: _________________________________________________________________

City: _______________________________________ State: _________ Zip: __________

Home Phone #: (____)____________________  Cell #: (____)____________________

Email: ____________________________________________________________________

Employer: ________________________________ Occupation:_____________________

- continued -
**Primary Physician Information**

Primary Physician’s Name: ___________________________________________________

Type of Physician: (circle all that apply)

MD  DO  Pectus Specialist  Pediatrician  Thoracic  Family  Other:___________________

Address: _________________________________________________________________

City: ______________________________________ State: ________ Zipcode: ________

Phone #: (___)______________________ Fax#: (____)___________________________

**Referring Physician** (this is the doctor who prescribes the brace)

__ Check here if same as primary physician. If not, complete below:

Referring Physician’s Name: __________________________________________________

Type of Physician: (circle all that apply)

MD  DO  Pectus Specialist  Pediatrician  Thoracic  Family  Other:___________________

Address: _________________________________________________________________

City: ______________________________________ State: ________ Zipcode: ________

Phone #: (___)______________________ Fax#: (____)___________________________

- END -
T-JOE PECTUS BRACING SYSTEMS
RX PRESCRIPTION

Date: _____ / _____ / ______

Patient's Name: _______________________________________

Date of Birth: _____ / _____ / ______

Diagnosis:
___ Pectus Carinatum  __ Flared Ribs / Pectus Excavatum
   Q67.7         Q67.6

   ___Dispense T-Joe Brace as indicated
   ___Massage Therapy as indicated
   ___Exercise / Workout Program as indicated

Ordering Physician:
______________________________________________ MD / DO
   (print name or stamp)

Signature:______________________________________________

Address: ______________________________________________
   ______________________________________________

DEA / NPI : ___________________________________________

Phone Number: (_____) __________ - _____________________

Fax: (_____) __________ - ____________________

Notes / Special Request: ________________________________

877-732-8876
PectusServices.com
NOTICE OF PRIVACY PRACTICE ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

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

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses of disclosures of my health information. I understand that this organization(s) has the right to change its Notice from time to time and that I may contact them at any time to obtain the current copy of the Notice of Privacy Practices.

I understand that I may also request, in writing, that you restrict how my private information is used and or disclosed to carry out treatment, payment, or healthcare options. I also understand that you are not required to agree to my requested restrictions, but if you do agree to my requested restrictions, but if you do agree, you are bound to abide by such restrictions. I understand that request to forward my medical records to another provider / physician other than my primary care it must be in writing.

Patient Name Printed: _______________________________________________________

If Minor - Parent / Guardian Signature: _________________________________________

Patient Signature (if of age of majority): _______________________________________

Date Signed: _____ /_____ /__________
Medical Information Release Form

FOR:  Patient Name: _______________________________________________________

Patient Date of Birth: _____ / _____ / __________

Authorization: I hereby authorize Pectus Services LLC and Pectus Services of Utah, New York, Maryland, California, or Arizona to furnish and / or obtain the above named patient’s health records and any information pertaining to the medical history, physical condition, previous services / care / treatment / tests rendered, or treatment of pectus from the following Physicians or Medical Facility(s):

________________________________________________________________________

This authorization is limited to the following medical records: History/Physical Examination, Consultation Reports, Progress Notes, Surgery Notes, Laboratory Tests, X-Ray, CT, MRI Reports, Photographs or other images or Other: ______________________

This disclosure of health information is required for the following purpose(s):

The non-surgical improvement of a chest wall deformity such as: Pectus Carinatum, Pectus Excavatum, Costal Arch Inversion (Rib-Flaring) using all or any of the following: Brace (compressive orthosis which is an FDA registered medical device), Strength Exercises, Massage Therapy, Flexibility and Stretching Methods and Aerobic Exercise.

_________________________________________    __________    __________________________
Signature              Date             Witness

_________________________________________  Phone:  H:(___) ____________ Cell:(___) ____________
Relationship to Patient
PECTUS SERVICES FINANCIAL & HEALTH INSURANCE AGREEMENT

We would like to take a moment to welcome you to our office and assure you that you will receive the very best professional services available for your pectus condition. In order to familiarize you with the financial policy of this office we would like to explain how we can provide the best care and submit to your insurance. Be sure to understand that having ‘Coverage’ for bracing by your insurance company does not mean that it will be ‘Approved’. An example of this is (You can have coverage but your claim may still be denied / not approved). Please understand that you are responsible for the entire amount regardless of your insurance status.

Explanation of Insurance Coverage:
Many insurance policies cover durable medical equipment (TJoe Brace) but this office makes no representation that yours does, nor that they guarantee approval of your claim. Insurance policies may vary greatly in terms of deductible and percentage of coverage in your policy for durable medical equipment. We will do our best to verify your insurance coverage prior to your appointment and will bill your insurance in a timely manner as a courtesy to you.

Payment Arrangements
We require that you pay the amount due as determined by verification of benefits at the time of your appointment / service. Next your claim will be submitted to your insurance as a courtesy to you and payment will be sent directly to you. After the claim is submitted to your insurance, any remaining balance is expected to be paid 30 days of the invoice date. Payment plans are welcome. A collection agency is used to collect the remaining balance after 30 days unless other arrangements have been made.

If you have any questions or concerns please contact our insurance department by calling our office: 877-732-8876 or by email: info@pectusservices.com. If your insurance company requires medical reports, records or doctors notes to document your pectus treatment or progress, your signature below authorizes this office to release the medical information necessary to process your claim.

We hope this answers any questions you might have concerning the financial policy of this office. Once again we welcome your to our office, and will be glad to answer any further questions that you might have.

I have read and agree to the above for patient: ________________________________

_____________________________                 __________________
Signature of Patient or Parent (if minor)             Date
Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Pectus Services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Pectus Services to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of a lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Pectus Services on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

__________________________________
Patient/Responsible Party Signature

__________________
Date

__________________________________
Witness

__________________
Date
Medical Photo Permission Form

This consent and authorization form has been prepared to obtain your permission for Pectus Services LLC (hereinafter “Pectus”) and/or Pectus Services of Maryland, California, Utah, Arizona, or New York, LLC hereinafter “Pectus”) to take photographs of you (hereinafter “subject”), as described below, for the purposes set forth in this document. It is important for you to review this document. By signing this document, you consent to having your photograph taken before, during and after bracing periods and exercise solely for the purpose of monitoring progress, care to the subject and improvement of the subject over time. These photos are from the chin down to the navel and do not show the face nor will have any personally identifiable information disclosed in the photographs or otherwise, and at no time will your name or identity be disclosed. Pectus Services LLC and/or one of its Affiliates shall have the right to edit the photographs in any reasonable manner to improve the quality of the photograph and/or to protect your anonymity. By signing this document, you acknowledge that you understand the contents of this document and have agreed to execute it of your own free will. If you are under the age of 18, your parent or legal guardian must sign this document and by doing so consents to the provisions set forth above.

**Client** PRINT Full Name: _____________________ Date of Birth: ____ / ____ / 20_____

**Client** SIGN Full Name: _____________________ Date Signed: _____ / ____ / 20_____

- For patients under the age of majority a parent or legal guardian must also sign

**Parent** / Legal Guardian PRINT: ____________________________________________

**Parent** / Legal Guardian SIGN: ____________________________________________

Home Address: ________________________________ City: _________________________

State: _____ Zip / Postal Code: ___________ Date Signed: _____ / _____ / 20_____
Model Photo Release Form for Pectus Services LLC

I hereby agree to allow my photograph(s) to be used by Pectus Services, LLC (“Pectus”) or one of its affiliate companies (Pectus Services of Maryland, Utah, Arizona, New York, or California (also referred to as “Pectus”) for use and display on Pectus’s website and other marketing material, and hereby assign any and all copyright to and in this/these photograph(s) (in any and all form or format currently existing or existing in the future) (together, the “Image(s)”) to Pectus, together with the right of reproduction either wholly or in part. I understand it will show my face but not any identification such as name, address etc.

I agree that Pectus and its licensees or assignees can use the Image(s) either separately or together, either wholly or in part, in any way and in any medium or format (now existing or existing in the future). Pectus and its licensees or assignees shall be and hereby are granted the unrestricted use of the Image(s) for whatever purpose in connection with its business, including advertising, with any reasonable retouching or alteration.

I agree that the Image(s) and any reproductions thereof may be described or deemed to represent an imaginary person or character in advertising or otherwise. I agree that I shall not prosecute or to institute any legal proceedings, arbitration demands, or claims or demands against Pectus or any of its officers, directors, members, owners, employees, agents or assigns (together, the “Released Parties”) with respect to the use of any or all of the Images, and hereby waive and release any and all claims or damages of any kind or sort against each and all Released Parties in connection with the Images or use thereof.

Any and all disputes concerning or related in any way to this Release Form or the rights or obligations hereunder, shall be resolved exclusively in the State or Federal Courts and shall be governed exclusively in accordance with the law of the State or the United States, as the case may be.

I have read this Release Form carefully and fully understand its meanings and implications. I represent and warrant that I am over the age of 18 and that I have the right to contract in my own name (or, if not, that my parent or guardian has signed below and that such parent or guardian has the right, power and authority to execute this contract). I have also had the opportunity to have an attorney of my choice, at my cost, to review this Release Form prior to my signing this agreement.

Client PRINT Full Name: _________________________________ Date of Birth: ___ / ___ / ______

Client SIGN Full Name: _____________________________ Date Signed: _____ / ____ / 20______

- For patients under the age of majority a parent or legal guardian must also sign -

Parent / Legal Guardian PRINT: ______________________________________________________

Parent / Legal Guardian SIGN: ______________________________________________________

I / We decline to allow my photos to be used in the above manner.