

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 doctor 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, HIPAA, 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)

- |  |   |
|--|---|
| <input type="checkbox"/> Breathing difficulty    | <input type="checkbox"/> Easily winded                |
| <input type="checkbox"/> Chest pain              | <input type="checkbox"/> Self esteem                  |
| <input type="checkbox"/> Avoid sports            | <input type="checkbox"/> Flared ribs                  |
| <input type="checkbox"/> Asthma-like symptoms    | <input type="checkbox"/> Avoid swimming               |
| <input type="checkbox"/> Avoid changing in gym   | <input type="checkbox"/> Never show bare chest        |
| <input type="checkbox"/> Scoliosis               | <input type="checkbox"/> Slumped shoulders            |
| <input type="checkbox"/> Round / bulging belly   | <input type="checkbox"/> Forward lunched head         |
| <input type="checkbox"/> Wear clothes to hide it | <input type="checkbox"/> Swayback / curve in low back |
| <input type="checkbox"/> Uneven shoulders        | <input type="checkbox"/> 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  
Q67.7

\_\_\_ Flared Ribs / Pectus Excavatum  
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, XRay, 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.

### Explanation of Insurance Coverage:

Many insurance policies cover durable medical equipment (TJoe Brace) but this office makes no representation that yours does. 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

I understand that I am responsible for the amount due of \$3,500.00 at time of bracing unless other arrangements such as a payment plan have been made. Your claim will be submitted to your insurance as a courtesy to you and payment may be sent directly to you.

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

## Assignment of Benefits Form

### 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 x 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.



## EXERCISE LOG

Name: \_\_\_\_\_

Workout: \_\_\_\_\_

	DATE:	DATE:	DATE:	DATE:
	REPS/LBS	REPS/LBS	REPS/LBS	REPS/LBS
<b>1</b>				
<b>2</b>				
<b>3</b>				
<b>4</b>				
<b>5</b>				
<b>6</b>				
<b>7</b>				
<b>8</b>				