PECTUS SERVICES
Changing Lives Through Superior Pectus Care Since 1996

Business Office:
6 Pinewood Road
Holland, NJ 08848-2235
877-732-8876

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, 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.

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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 –

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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 –

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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 –

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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 –

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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 –

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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

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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: _____ /_____ /_________

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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

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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
I understand that I am responsible for the amount due of $3,500.00 at time of bracing. Your claim will be submitted to your insurance as a courtesy to you. Reimbursement payments from your insurance company 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

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Assignment of Benefits Form

Financial Responsibility
All professional services rendered are charged to the patient and are due at the time of service. The required forms must be completed and sent to our office in order for us to submit your claim to your insurance carrier payments for reimbursement.

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

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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_____

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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.