READI⊖STEADI®

Anti-Tremor Orthotic Glove System

Online Application & Authorization Form

Patient's First Name:_____Middle Initial _____Last Name:_____

Patient's Date of Birth:_____ Patient's Phone #:_____

Patient's Last 4 Social Security Number:_____ Male or Female: _____

Patient's Street Address:_____

Patient's City, State, Zip Code _____ _____

Are you living in a Skilled Nursing Facility:_____ Are you currently participating in an In-Patient Rehab: _____

Shipping Address if Different: _____

City, State, Zip Code: _____ _____

Patient's Email Address (REQUIRED):_____
(if patient doesn't not have email, then a family member's email address)

Patient's Referring Doctor's Name:_____ Phone # _____

Which hand is dominant:_____ Affected:_____ Diagnosis: _____

Date of onset of symptoms:_____

Are you currently working with a local Occupational or Physical Therapist: _____

If yes, name and phone number:_____

Do you have health insurance or are you Self-Pay: _____

Primary Insurance:_____ ID# _____

Phone number:_____Termination date of insurance:_____

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Secondary Insurance _____ ID# _____

Phone number: _____ Termination date of insurance: _____

List 3 functional tasks difficult or unable to perform due to tremors/ataxia/abnormal movement pattern experienced:

1. _____
2. _____
3. _____

Briefly describe your work history/hobbies:

1. _____
2. _____
3. _____

AUTHORIZATION TO USE AND DISCLOSE PATIENT INFORMATION TO PATIENT'S PHYSICIAN AND INSURANCE COMPANY:

All visitors to the Readi-Steadi website understand that their participation and/or involvement in any activity or treatments through this website including use and or treatment via the Readi-Steadi device carries with it the potential for certain risks, some of which may not be reasonably foreseeable. All visitors to the Readi-Steadi website further acknowledge that these risks could cause them or others around them harm, including, but not limited to, bodily injury, damage to property, emotional distress, or other injuries. Despite these risks visitors to this website are willing to participate in any activities provided via this website. By browsing this website, all visitors Agree to release, indemnify, and hold harmless Readi-Steadi, LLC as well as all {their/its} employees, agents, representatives, successors, etc. from all losses, claims, theft, demands, liabilities, causes of action, or expenses, known or unknown, arising out of their participation in any activities and treatments provided via this website including but not limited to the Readi-Steadi® Anti-Tremor Orthotic Glove System.

I, the undersigned, understand that Krista Madere will recommend a customized Readi-Steadi® Anti-Tremor Orthotic Glove System with instructions on how to place my order after my video assessment and/or spiral drawing submission has been completed and I understand that each component is billed separately and can include up to four (4) components, (Right Hand, Right Elbow, Left Hand, Left Elbow), depending on my individual needs. Once I receive my customized Readi-Steadi® Anti-Tremor Orthotic Glove System, I will schedule or submit video to provide feedback on the fit and receive instructions for any adjustments from Krista Madere, as needed.

Readi-Steadi® products are custom made to each individual customer and are therefore not refundable.

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The products and/or services provided to you by (supplier legal business name or DBA) are subject to the supplier standards contained in the Federal regulations shown at 42 Code of Federal Regulations Section 424.57(c). These standards concern business professional and operational matters (e.g. honoring warranties and hours of operation). The full text of these standards can be obtained at http://www.ecfr.gov. Upon request we will furnish you a written copy of the standards.

We cannot guarantee that the device will solve all of your medical problems. But we can guarantee the device will be fit as prescribed. I am satisfied with the workmanship, notable benefit and fit of the device at the time of delivery. I have been fully advised as to the use of this appliance and understand its limitations.

I understand that the company will not be responsible for any changes or additions to this appliance not ordered by the prescribing physician or in the event the appliance has been altered or repaired by anyone other than the representatives of the company. There are no refunds.

In consideration of professional services rendered, I hereby assign benefits due me covering the services under the above Medicare or private insurance policy numbers to Readi-Steadi, LLC. I authorize any holder of medical information about me to release to the above insurance company and its agents any information needed to determine these benefits payable for related services.

When we verify your insurance benefits, if for any reason we are given the incorrect information and the Explanation of Benefits indicates that you are responsible for more, you will receive a statement for the balance due. Any balances owed are due upon receipt of the statement.

If for any reason you have a credit, you will be issued a refund upon receipt of the Explanation of Benefits.

I hereby acknowledge that I fully understand the above and agree to make any additional, necessary payments due according to my insurance.

WARRANTY:

All off-the-shelf and custom fabricated products sold by
Readi-Steadi, LLC have a warranty period of 3 months on all workmanship. Any changes in the patient status that caused the device to be out of fit or function improperly are not covered under warranty. The changes in patient status include but are not limited to; weight loss or gain, limb atrophy or hypertrophy, and increase or decrease in patient functional level. Any damage beyond normal wear and tear is not covered under warranty.

Adjustments and repairs within 3 months of delivery date will be made at no charge when the adjustments or repairs are not necessitating by patient status change.

Adjustment and repairs after 3 months of delivery date will be subject to fees according to adjustments and or repairs necessary.

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_____ _____

Signature of patient or caregiver **Date**

_____

Patient's Printed Name

SHARING YOUR TESTIMONY:

I authorize Readi-Steadi® Orthotic Glove System (including their respective employees, contractors and other staff members) (collectively, "Provider"), directly or indirectly through its agents or other representatives, to use and disclose (i) the information contained in any testimonial(s) I provide to Provider, in whole or in part, including information relating to the care and treatment I received from Provider, and (ii) any other information relating to my case and the treatment I received from Provider, including my name, image, likeness, picture, or other details that would disclose my identity (collectively, my "Patient Information"), in each case for marketing and advertising purposes in print, audio-visual, electronic or other media form (including, without limitation, on TV, radio, print (e.g., brochures/flyers and newsletters), internet, web advertising and social media sites).

I further authorize Provider to photograph me and make audio and video recordings of my testimonial, medical condition and the care and treatment I received from Provider, which shall constitute Patient Information hereunder. I waive the right to inspect or approve Provider's use or disclosure of my Patient Information, and I understand that my Patient Information may be edited or modified by Provider. I understand that once my Patient Information is disclosed pursuant to this Authorization, it could be disclosed by the person or entity receiving such Patient Information. Such re-disclosure may no longer be protected by federal law and any applicable state laws.

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I understand that I will not receive any compensation (financial or otherwise) from Provider or any third parties for the use or disclosure of my Patient Information. I understand that signing this Authorization is voluntary and my treatment, payment, or eligibility for benefits will not be conditioned upon execution of this Authorization.
I understand that I may revoke this Authorization at any time by delivering a written notice to: Readi-Steadi® Anti-Tremor Orthotic Glove System, 433 Metairie Rd., Suite 115, Metairie, LA 70005. However, the revocation will not apply to actions taken by Provider prior to the time it receives my written notice. This Authorization shall expire ten (10) years from the date of my signature, unless I revoke this Authorization sooner. I have read and understand the terms of this Authorization, and I agree to those terms. I understand that I have a right to receive a copy of this Authorization upon my request.

Please sign below to indicate whether you agree or disagree to sharing your testimony:

Agree _____

Disagree _____

We will need a copy of your photo id, a copy of your insurance card(s), a physician order, clinical notes from a face-to-face visit with the physician that signs the order, a trace drawing of your hand/wrist and a video.

Suggested tasks needed for the video are listed below, as well as the link to upload the video:

1). Bring spoon to mouth.
2). Bring cup to mouth.
3). Write your name.
4). Your tremor at rest and/or holding phone

Upload your short video to the link below:

https://www.123formbuilder.com/form-4621676/video-upload-form

Trace your hand here

Name: _____ DOB: _____ Date: _____

Please draw a spiral beginning in the center and going counterclockwise.

Example:

Left Hand Baseline:

Left Hand Orthosis Intervention:

Name: _____ DOB: _____ Date: _____

Please draw a spiral beginning in the center and going counterclockwise.

Example:

Right Hand Baseline:

Right Hand Orthosis Intervention: