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 FOR MARKETING PURPOSES

I, the undersigned," 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 my medical condition and 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, such as Facebook).

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.

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.

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I understand that I may revoke this Authorization at any time by delivering a written notice to: **Readi-Steadi® Anti-Tremor Orthotic Glove System, 1603 N Airline Hwy Suite A, Gonzales, LA 70737.**
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.

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 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 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. I must place my order within 30 days or a new assessment will be required.
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.

I understand that the assessment fee of $150 is non-refundable if not scheduled within 30 days of purchase. The assessment fee of $150 includes video review before and after receiving custom system. **Readi-Steadi® products are custom made to each individual customer and are therefore not refundable.**

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 also understand a guarantee on components, (except compression covers), under normal use, is extended for 90 days after delivery, during which time the company will make any repairs necessary to maintain the appliance in good working condition. After 90 days a service charge, based on hourly rate and materials, will be made for any repairs.

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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.

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.

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

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

_____ _____

Signature of patient or caregiver **Date**

_____

Patient's Printed Name