nymotion®
Speech Solutions

GETTING STARTED

- Complete the customer intake form. **All sections must be completed.**
- Provide a photo or scan of **all insurance cards**.
- The **Customer Information Checklist** must be signed and dated by the user. If the user cannot sign or is a minor, this form must be signed by a parent/guardian/spouse/POA. The checklist is a release of information and is needed for us to comply with HIPAA.
- If you require a free trial device, please let us know, and we can arrange to provide one.
- Check with your local consultant for the latest version of our report template as well as the report template resource guide to assist with the completion of your justification.

nmotion™ Speech Solutions

Intake Form

CUSTOMER DEMOGRAPHICS

Device User Last Name: _____ Middle Initial: _____

Device User First Name: _____

DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Contact Person: _____

Preferred Language: _____

Primary Phone: _____ Cell Phone: _____

Email address for client communication: _____

☐ Do not call for marketing ☐ Consent for marketing contact

Medical and/or Speech Diagnosis: _____

FUNDING

Primary: _____ Policy#: _____ Group: _____

Secondary: _____ Policy#: _____ Group: _____

Tertiary: _____ Policy#: _____ Group: _____

☐ Self Pay ☐ Insurance Card is Attached

PHYSICIAN INFO

Dr. (prescribing): _____

Dr. Phone: _____ Dr. Fax: _____

Dr. Address: _____

SPEECH-LANGUAGE PATHOLOGIST (SLP) INFO

SLP Name: _____ SLP Phone: _____

SLP Email: _____

SLP Company/School: _____

SLP Address: _____

HIPAA/Customer Information Checklist

Device User Name: _____ **DOB:** _____

_____ **Mission, customer information, customer complaints, customer rights and responsibilities, and accreditation information (see Customer Handbook.)**

_____ **Acceptance of Services** - I understand by signing this agreement I authorize provision of products and/or services to me by Numotion. I also understand that the products and services provided are prescribed by my physician and that it is necessary that I remain under the supervision of my attending physician during the course of my care.

_____ **Medical Information Authorization** - I hereby authorize release to Numotion any, and all, of my medical records pertaining to my medical history, services rendered or treatments received from my physician(s), hospital or nursing agencies. In order to process insurance claims, I also hereby authorize Numotion to furnish to my insurance carriers, or school, any medical history, services rendered or treatment needed. I authorize sharing of documentation between school and Numotion (i.e. IEP). I also understand that my information may be subject to review by credentialing, accreditation or governmental agencies.

_____ **Assignment of Insurance Benefits -** I authorize direct payment of insurance benefits by my insurance company to Numotion. In the event that my insurance carrier does not accept "assignment of benefits," I understand that payments may be sent directly to me and that I am obligated to endorse and directly send such payments to Numotion for payment of my bill. I understand that I am obligated to report any changes in insurance coverage promptly to Numotion.

_____ **Financial Responsibility -** I understand that I am responsible to Numotion for all charges not covered by my insurance. I recognize that in the event that my insurance company, employer or any other third party payor refuses to pay the purchase price(s) of the above items, or delays payment beyond 90 days of my receipt of items, or in the event that I have no insurance coverage or third party payor, that I will be responsible for said payments and will make prompt reimbursement within 30 days of notification by Numotion on for all charges.

_____ **If you have Medicaid -** I understand that if I have Medicaid I am not financially responsible for covered items as long as my Medicaid number is active at the time of delivery. I further understand that I may/will be responsible for charges if my Medicaid status changes. I will notify Numotion of any changes in my Medicaid coverage.

_____ **Return Policy -** The equipment Numotion sells is custom/specialized or ordered special and is not returnable. I authorize Numotion to send email order status updates to me, my caregiver and / or my clinician.

_____ **Photographic Release -** I hereby grant permission to Numotion to take photographs/video which may be used to document medical necessity for equipment or services provided by Numotion, and which may be submitted to insurance payors or other medical professionals as needed for evaluation on and/or consultation. I hereby release Numotion from any liability associated with these photographs/videos so long as they are used for the purposes as described above.

_____ **Permissions for Numotion to share information and documentation includes but is not limited to the following:**

_____

_____

Signature: _____

Date: _____

Printed Name of Person Signing: _____

Realtionship to Device User: _____

Please call 585.895.6411 or 585.385.1902 with any questions.