WIGS N MORE, INC: MASTECTOMY & WIG BOUTIQUE

Enclosed are the forms that you will need to fill out and return to us so that we may start the wig purchasing process. Please make sure to fill out your complete doctor's information on client assessment/profile form.

The compliance assurance notification & customer bill of rights forms are yours to keep.

Also needed is the following documentation:

1. Copy of your Driver License or Photo ID
2. Copy of your insurance card(s) Front & Back
3. Prescription from your Doctor with your diagnosis code, if available
4. PLEASE SEND COPIES OF ALL INSURANCES, PRIMARY & SECONDARY

WE NEED A COPY OF YOUR PRIMARY, EVEN IF IT DOESN'T COVER A WIG TO BILL

Please send the required forms back to us at your earliest convenience to get the process started

Email: info@wigsnmore.net

Fax: 724-532-0701

Mail: 5924 Route 981 Suite 3

Latrobe, PA 15650

We look forward to working with you...

Wigs N More

Please visit our website @ www.wigsnmore.net

YOU HAVE 7 DAYS FROM RECEIPT OF WIG(S) TO MAKE ANY RETURN OR EXCHANGE WIG(S)

WIGS N MORE, INC. MASTECTOMY BOUTIQUE

Client Assessment/Profile Form

Client: _____ Date: _____ SS# _____

Address: _____ ***Date of Birth***: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Married? Yes _____ No _____ Other _____ EMAIL ADDRESS _____

Employed? Yes _____ No _____ Employer: _____ Gender M F

Next of Kin _____ Relationship to patient _____ Phone _____

Insurance Information

Primary: _____ Secondary: _____

Copy of all cards received: Yes ___ No ___ On File _____ Verification: _____

Insurance Allowable: _____ Co-Pay: _____

Pre Authorization #: _____ Diagnosis code(s) _____

Doctors Name: _____ ***Phone #*** _____ NPI# _____

Address _____

Signature: _____ **Date:** _____

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it's appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name:_____ Signature: _____Date:_____

WIGS N MORE

MASTECTOMY BOUTIQUE

RELEASE OF INFORMATION

I, the undersigned, do hereby approve WIGS 'N MORE MASTECTOMY BOUTIQUE to release to insurance companies and doctor's offices the information required to receive authorization to assure payment of any portion of the bill incurred by myself that they are entitled to receive. That information being: my name, address, date of birth, the name of the doctor authorizing prescriptons, my client number, and the code numbers of the products required.

PRINT
NAME_____ **DATE**_____

SIGNATURE_____

WIGS 'N MORE INC AND MASTECTOMY BOUTIQUE

5924 Route 981
Suite 3
Latrobe, PA 15650

FAX AND MESSAGE AUTHORIZATION

Dear Patient/Customer,

In accordance with new privacy laws dictated by HIPAA, we can no longer fax medical information or leave messages on your phone or with another person without your written consent.

_____**I give my permission** for the staff of Wigs 'n More Inc and Mastectomy Boutique to **fax** medical information relating to services provided. NOTE: This is to fax a script to Doctor's office for products to be disbursed.

_____I **DO NOT give my permission** for the staff of Wigs 'N More Inc and Mastectomy Boutique to **fax** medical information relating to services provided.

_____**I give my permission** for the staff of Wigs 'n More Inc and Mastectomy Boutique to **call and/or leave a message** at the following phone number _____concerning the receipt of shipments of products and /or relating to services provided.

_____I **DO NOT give my permission** for the staff of Wigs 'n More Inc and Mastectomy Boutique to **call and/or leave a message** concerning the receipt of shipments of products and/or relating to services provided.

Patient/Customer's Name (print) _____

Date of Birth _____

Patient/Customer Signature _____

Date _____

Thank you,

Kathleen Hendirckson
Owner

CLIENT FINANCIAL RESPONSIBILITY FORM

Your signature below forms a binding agreement between Wigs 'N More and YOU the client of Wigs 'N More that is receiving services or the Responsible Party for eligible dependants. The Responsible Party is the individual who is financially responsible for payment of insurance bills.

All co insurances and upgrade charges are to be paid within 30 days of receiving a statement from our facility. When Wigs 'N More receives an explanation of benefits (EOB) from your insurance company, any amount stated on that EOB will be billed to you.

- We will bill you insurance company(s) as a service to you. As the responsible party, you are ultimately responsible if your insurance company(s) declines payment for any reason.
- Patient must inform Wigs 'N More of all address, phone number and Insurance changes in a timely manner to ensure proper billing of services.

RETURN CHECK POLICY: If payment is made on your account by check, and the check is returned as Non – Sufficient Funds (NSF), Account Closed (AC, or Refer to Maker (RFT), the patient or Patient's Responsible Party will be responsible for the original check amount plus a $25.00 Service Charge. Once noticed is received Wigs 'N More will send out a letter to notify you and a response must be made within 15 days of receipt to make alternate payment.

SIGNATURE: _____

PRINT NAME: _____

DATE: _____

WIG RETURN POLICY

YOU HAVE 7 DAYS FROM RECEIPT OF WIG(S) TO MAKE ANY RETURNS OR EXCHANGES.

WIGS CAN BE TRIED ON, BUT DO NOT WEAR WIG(S) FOR ANY LENGTH OF TIME WHILE DECIDING IF STYLE AND COLOR IS RIGHT FOR YOU.

ALL TAGS MUST BE KEPT ATTACHED TO WIG(S)

WIG(S) MUST BE SHIPPED BACK IN ORIGINAL PACKAGING

IF ANY HAIR PRODUCT IS USED ON THE WIG(S), INCLUDING WASHING, THEY CAN NO LONGER BE RETURNED (MOUSSE, HAIRSPRAY, ETC...)

IF A WIG(S) HAS BEEN CUT, SEWN OR ALTERED IN ANY WAY IT CAN NOT BE RETURNED

WIGS WILL BE INSPECTED UPON RECEIPT, YOU WILL BE CHARGED IF A WIG(S) IS NOT IN SAME CONDITION AS YOU HAVE RECEIVED IT FROM THE MANUFACTURER.

PLEASE RETURN WIGS TO: WIGS N MORE
5924 RTE 981
LATROBE, PA 15650

PRINT NAME_____

SIGNATURE_____

DATE_____

Wigs 'n More, Inc.
& Mastectomy Boutique

5924 Route 981, Suite 3, Latrobe, PA 15650
Phone: 724-532-1901 • Fax: 724-532-0701 • Info@WigsNMore.net • wigsnmore.net

Compliance Assurance Notification

To Our Valued Patients

The misuse of Personal Health Information (PHI) has been identified as national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers, and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients

It is our policy to properly determine appropriate uses of PHI in accordance with the governmental rules, laws, and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosures of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of the fact, our policy is to listen to our employees and our patients without any thought of personalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problems so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.

Wigs 'n More Inc. & Mastectomy Boutique
5924 Route 981
Suite 3
Latrobe PA 15650

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& Mastectomy Boutique

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Customer Bill of Rights

1. The Wigs 'n More Inc. & Mastectomy Boutique is committed to serving your needs by providing you with quality products.
2. The Wigs 'n More Inc. & Mastectomy Boutique is committed to helping you with you fitting, always with your personal needs in mind.
3. The Wigs ‘n More Inc. & Mastectomy Boutique welcomes exchanges if necessary to give you a perfect fitting, within a reasonable amount of time. We will refund your money if you are not completely satisfied.
4. The Wigs ‘n More Inc. & Mastectomy Boutique is committed to always treating you in a caring and professional way.
5. The Wigs ‘n More Inc. & Mastectomy Boutique will ship as quickly as possible after receiving your order, generally within 72 hours of receipt of your order.
6. The Wigs ‘n More Inc. & Mastectomy Boutique will provide an explanation of our mastectomy products, prices, care of product, guarantees, and warranties.
7. The Wigs ‘n More Inc. & Mastectomy Boutique welcomes your suggestions and questions. We will address your complaints immediately. Please contact us if you are unhappy in any way.
8. The Wigs ‘n More Inc. & Mastectomy Boutique will file all Medicare claims as required by law.
9. The Wigs ‘n More Inc. & Mastectomy Boutique will refer you to the appropriate DMERC when we cannot answer your Medicare questions.
10. The Wigs ‘n More Inc. & Mastectomy Boutique will provide a copy of Medicare Supplier standards to each Medicare customer.
11. The Wigs ‘n More Inc. & Mastectomy Boutique, in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPA), will make your records available to you to view and copy with the right to amend. To make this request, call Kathleen Hendrickson, Compliance Officer, at 724-532-1901.
12. The Wigs ‘n More Inc. & Mastectomy Boutique will protect the privacy as stated in the HIPAA privacy practices information you received and acknowledged.
13. The Wigs ‘n More Inc. & Mastectomy Boutique will review this Bill of Rights with our Fitting Counselors in our ongoing training program.

Wigs 'n More, Inc.
& Mastectomy Boutique

5924 Route 981, Suite 3, Latrobe, PA 15650
Phone: 724-532-1901 • Fax: 724-532-0701 • Info@WigsNMore.net • wigsnmore.net

Proper Wig Care

Human Hair Wig Care Instruction

- Gently detangle hair using a wig brush or wide-toothed comb from bottom to top.
- Holding the wig in your hands, wet wig with cold water.
- Gently work wig shampoo through hair from top to bottom.
- Rinse thoroughly with water.
- Gently pat dry with a towel, do not wring or twist wig.
- Comb wet hair from bottom to top (use gentle downward strokes).
- NEVER being combing from top or middle of hair.
- Allow wig to dry on wig stand (do not place wet wig on a mannequin head, this may stretch out the wig cap).
- To restyle your wig, you may use a curling iron or blow dryer on low heat settings.

Synthetic Wig Care Instruction

- Before washing wigs, gently brush/comb out all tangles and any hairspray build-up. If you have a longer wig or hair add-on with a tight or an all-over-curl, DO NOT BRUSH-finger pick thoroughly to remove tangles.
- Only use products specifically formulated for wigs.
- Fill sink with cool water, add one tablespoon of shampoo, gently wash wig then let rest for 10-15 minutes. Rinse, drain water, press water out between palms of hands. DO NOT wring/rub fibers.
- Repeat procedure using one teaspoon of conditioner.
- Rinse, press out excess water between palms of hands, then pat with towel. Shake to remove any excess water.
- Allow wig to air dry on wig stand. DO NOT USE a Styrofoam head: this will cause the wig to stretch. Apply wig styling products-mousse, gel, spray, or revitalize (underneath only for long wigs).
- If hair falls toward/in face, slightly wet with spray bottled water and brush hair repeatedly backward to re-direct the knot.
- Style with metal wide tooth comb. Allow to dry overnight then shake loose, finger style and give final spray.

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Proper Wig Care (cont.)

- IMPORTANT: DO NOT USE a hairdryer, curling iron, or other curling aid. Any high temperature can easily damage a wig.
- If you wear your wig every day, wash it at your discretion.

What Not to Do While Wearing Your Wig

- Do not use a curling iron, straightener, or hair dryer on synthetic wigs.
- Stay away from open flames, such as fireplaces, grilling, or bonfires.
- While cooking, stay away from boiling pots, opening ovens, and do not open a hot dishwasher.
- Do not light a cigarette while wearing a wig.
- Do not blow out candles while wearing a wig.
- If you have any question, or concerns about your newly purchased piece, please do not hesitate to call us. We are here for you!

Wigs n More
MASTECTOMY BOUTIQUE

AETNA FORM INSTRUCTIONS

Aetna Insurance requires additional forms with your signature.

Aetna is very particular about how these forms are completed and we will complete the forms for you to assure everything is exactly how Aetna wants it. We'll have all the information we need from your packet.

ALL YOU NEED TO DO is to sign these forms where we have the yellow highlights and return them to us.

BY MAIL	**BY FAX**	**SCAN AND UPLOAD TO OUR HIPAA COMPLIANT SYSTEM**
Wigs 'n More, Inc. 5924 Route 981 Suite 3 Latrobe, PA 15650	724-532-0701	https://wigsnmore.net/aetna

DO NOT EMAIL THESE FORMS AS THEY CONTAIN CONFIDENTIAL INFORMATION.

amoena

AETNA POST MASTECTOMY

CONFIRMATION OF BENEFITS FORM

COMPLETE ALL SECTIONS AND FAX TO AMOENA USA CORP AT: 1-877-726-7702 Phone: 1-800-811-5659

ICD 10:

SECTION I – RETAILER INFORMATION (Retailer to Complete)			
Date of Verification Request:			
Retailer Store Name:		Amoena Account #:	
Phone:		Fax:	

SECTION II – MEMBER INFORMATION (Retailer to Complete)			
Last Name		First Name	
Date Of Birth		Member ID	
Group #		Phone #	
Address:		City, State, Zip	

SECTION III – PHYSICIAN INFORMATION (Retailer to Complete)			
Primary Care Physician		Physician ID#	
Physician Phone Number		Rx attached?	YES____ NO_____

SECTION IV - PRODUCT INFORMATION (Retailer to Complete)			
PLEASE LIST NON UPGRADEABLE BRA AND FORM SHOWN TO MEMBER			
Bra:		Form:	
PLEASE LIST ITEMS TO BE PURCHASED			
HCPC		Quantity	
HCPC		Quantity	
HCPC		Quantity	
HCPC		Quantity	

SECTION V – APPROVAL CONFIRMATION (Amoena USA Corp. to Complete)

AUTHORIZATION OF BENEFIT NOT VALID AFTER 30 DAYS

Deductible Due	$	**Deductible Start: _____ Deductible Remaining: _____** **Co-insurance: _____% L8015: _____ L8000 _____ L8030 _____** **L8020 _____ L8032 _____ L8001 _____ L8002 _____**
Co-pay/Coins Due	$	
TOTAL DUE FROM MEMBER AT TIME OF SERVICE	$	

_____ Amoena Verifications Coordinator:	_____ Date:	_____ Verification Valid Through:

SECTION VI – ASSIGNMENT OF BENEFITS (Patient to Complete)

I request that payment of authorized medical insurance benefits be made directly to Amoena on any unpaid bill for medical supplies and equipment for the period of medical necessity prescribed by my physician, and listed on the invoice. In addition, I authorize any holder of medical or other information to release any data about me needed to determine benefits for related services to Amoena USA Corp**. I understand that my insurance may have a limit or dollar allowance for the items listed above. If any item I have chosen to purchase is not covered by my insurance, or includes a non-covered upgrade, I will be responsible for payment of the non-covered upgrade, as specified above, in addition to any applicable copayment, coinsurance or deductible. I am aware that the total amount due is subject to final payment processing made by my insurance to Amoena USA Corp.**

_____ _____

Patient's Signature Date

I, _____, the undersigned confirm that I have received all products identified on this Confirmation Of Benefits Form and am awaiting receipt of no additional product.

_____ _____

Patient's Signature Date

Amoena to Date Stamp all Sections	Date Stamp Section I – III	Date Stamp Section IV - V	Date Stamp Section VI Claim is complete – Pay retailer

Revised November 1, 2017

amoena

AETNA COMPRESSION, WIGS & BREAST PUMPS ONLY

CONFIRMATION OF BENEFITS FORM
COMPLETE ALL SECTIONS AND FAX TO AMOENA USA CORP AT:
Fax #: 1-877-726-7702 **Phone #: 1-800-811-5659**

ICD 10:

SECTION I – RETAILER INFORMATION (Retailer to Complete)			
Date of Verification Request:			
Retailer Store Name:		Amoena Account #:	
Phone:		Fax:	
SECTION II – MEMBER INFORMATION (Retailer to Complete)			
Last Name		First Name	
Date Of Birth		Member ID	
Group #		Phone #	
Address:		City, State, Zip	
SECTION III – PHYSICIAN INFORMATION (Retailer to Complete)			
Primary Care Physician		Physician ID#	
Physician Phone Number		Rx attached?	YES____ NO_____

SECTION IV - PRODUCT INFORMATION (Retailer to Complete)					
PLEASE LIST ITEMS TO BE PURCHASED					
HCPC		Quantity		Charges (EACH)	$
HCPC		Quantity		Charges (EACH)	$
HCPC		Quantity		Charges (EACH)	$
HCPC		Quantity		Charges (EACH)	$
HCPC		Quantity		Charges (EACH)	$
HCPC		Quantity		Charges (EACH)	$

SECTION V – APPROVAL CONFIRMATION (Amoena USA Corp. to Complete) **AUTHORIZATION OF BENEFIT NOT VALID AFTER 30 DAYS**		
Deductible Due	$	**Deductible Start:** _____
Co-pay/Coins Due	$	**Deductible Remaining:** _____ **Coinsurance:**_____ **%**
TOTAL DUE FROM MEMBER AT TIME OF SERVICE	$	
_____ Amoena Verifications Coordinator	_____ Date:	_____ VERIFICATION VALID THROUGH

SECTION VI – ASSIGNMENT OF BENEFITS (Patient to Complete)

I request that payment of authorized medical insurance benefits be made directly to Amoena on any unpaid bill for medical supplies and equipment for the period of medical necessity prescribed by my physician, and listed on the invoice. In addition, I authorize any holder of medical or other information to release any data about me needed to determine benefits for related services to Amoena USA Corp**. I understand that my insurance may have a limit or dollar allowance for the items listed above. If any item I have chosen to purchase is not covered by my insurance, or includes a non-covered upgrade, I will be responsible for payment of the non-covered upgrade, as specified above, in addition to any applicable copayment, coinsurance or deductible. I am aware that the total amount due is subject to final payment processing made by my insurance to Amoena USA Corp.**

_____ _____
Patient's Signature Date

I, _____, the undersigned confirm that I have received all products identified on this Confirmation Of Benefits Form and am awaiting receipt of no additional product.

_____ _____
Patient's Signature Date

Amoena to Date Stamp all Sections	Date Stamp Section I – III	Date Stamp Section IV - V	Date Stamp Section VI Claim is complete – Pay retailer

Revised November 1, 2017