PSI Premier Specialties, Inc,
DBA Medical Express, PSI

Med
Patient Care. Medical Solutions

In partnership with Medical Express, Inc. and other affiliates ("the provider")

Toll-Free (HQ): 888-655-6339
Facsimile (HQ): 888-977-1138
Online: www.medexpsi.com

PATIENT PRODUCT AGREEMENT, RX AND PROOF OF DELIVERY

Location: WTSW ORTHO
(address where service provided)

Circle: **LEFT RIGHT B/L** *QTY: 1 ea. unless otherwise specified:* ___

LOCAL OFFICE CONTACT

AUSTIN	
(P) 512-371-1700	(F) 512-371-1754
SAN ANTONIO	
(P) 210-545-7070	(F) 210-545-7069
DALLAS	
(P) 214-575-0441	(F) 214-570-9199
TYLER	
(P) 903-526-6300	(F) 903-526-6301
HOUSTON	
(P) 713-465-1010	(F) 866-819-5417
CORPUS CHRISTI	
(P) 361-356-1483	(F) 361-452-8344
OKLAHOMA	
(P) 918-376-4180	(F) 866-859-2645

Patient Name: _____

PRESCRIPTION and ITEMS RECEIVED:

Please provide product description with manufacturer and part # or place stickers below

Place Product Sticker Here
(if available)

REF B-242900063 LOT WB240222
REBOUND AIR WALKER LOW TOP MD
HCPCS: L4361 L4360

CPM
__Knee CPM with Pad Kit
__Shoulder CPM with Pad Kit

ROM Settings: _____
LON (# of Days): _____
Stop Date: _____

Date of Surgery: _____
Date of Application: _____
Date of Discharge: _____

Letter of Medical Necessity: I certify that the above are required during the normal course of patient rehabilitation in order to protect the injury and/or surgical repair. This will allow the patient to resume the normal activities of daily living more quickly and at less cost. These modalities are an essential adjunct to the patient's rehabilitation. Without the use of this device, the patient will be at risk for extended rehabilitation and additional costs. I certify that I have fit and adjusted the item to the patient.

Physician Signature: _____ **Order Date:** 4/28/25 **NPI#:** _____
***ORIGINAL Physician Signature REQUIRED for Medicare beneficiaries**

Physician Name: Steven Skiles PA-C Facility: _____

Diagnosis/ICD-10 Code(s): S90.31XA S93.491A Procedure: _____

Please Attach:
Demographics
Insurance
Medical Records

Patient Acknowledgement, Authorization for Assignment of Benefits (PA/AOB) and Proof of Delivery Acknowledgement:

I, _____ (patient name) acknowledge receipt of the item(s) noted above in the "Prescription and Items Received" section. I request that payment of authorized insurance be made on my behalf to Medical Express, PSI or an affiliate of Medical Express, PSI ("the provider") for products & services that they provide to me. I further authorize a copy of this agreement to be used in place of the original to release to payers any information needed to determine these benefits or compliance with current healthcare standards. I consent for the provider to use my Protected Health Information in all activities related to seeking insurance payment for the equipment and/or supplies I received. The provider bills third party payers as a courtesy; I understand that I am fully responsible for all deductibles, co-insurance and insurance allowables. I understand company business hours & that the provider representative will be contacting me regarding my financial responsibilities related to this agreement. I expressly consent to receiving auto-dialed and/or pre-recorded messages, emails, text messages or other electronic communication from the provider for any reason by using any telephone number, email address, and/or mailing address associated with my account. Additionally, I acknowledge receiving instruction, have demonstrated or verbalized my understanding in the proper use and care of the equipment or supplies described on this document and will follow them. **I understand that the provider is under regulation set forth by Medicare, state licensing boards, and accrediting organizations. Therefore, products are under limited warranty and are non-returnable except in the event of a defective or improperly fit product** *(rental items are returned after the rental period unless defective and needs replacement).* I acknowledge receipt & understand the company patient information privacy notice provided to me and that all information on this document is correct. I further agree to all terms and conditions on the back of this form. The products and/or services provided to you by the provider 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://ecfr.gpoaccess.gov. Upon request we will furnish you a written copy of these standards.

Patient/Authorized Signature: _____ **Delivery/Receipt Date:** 4/28/25

Patient Info for RX and Proof of Delivery:

Patient Name: _____
Billing Address: _____ **Apt #:** ___
City: _____ **State:** ____ **Zip:** _____
Home Phone: _____ **Cell Phone:** _____
Date of Birth: _____ **Email:** _____

BLACK, CHARMERIA 96288520
432 Round Rock Rd Cedar Hill TX 75104-5*
6/12/1989 (41 yrs) 214-791-5845 FEMALE
CSN 726291007 DOS 4/28/25
AETNA HEALTH PLANS */AETNA U.S. HEALTHCA*

For Internal Use Only

- ☑ Patient/caregiver has been educated on the purpose and function of the device; the proper cleaning, care, and use of the device; potential risks/benefits and precautions; how to report any failures and malfunctions; and when and whom to report changes in physical conditions.
- ☐ Patient/caregiver has been instructed on infection control related to the device.
- ☐ Patient/caregiver has been instructed on how to inspect the skin for pressure areas, redness, irritation, skin breakdown, pain, or edema.
- ☐ Patient/caregiver has demonstrated that they can safely and effectively use the equipment in the setting of anticipated use.
- ☐ The equipment/device has been assessed for structural safety and assured that manufacturer guidelines are followed.
- ☐ The patient's goals and outcomes have been discussed with the patient/caregiver. Specific goals/outcomes: _____

Signed: _____ **Date:** 5/08/25

UT SOUTHWESTERN MEDICAL CENTER

Orthopaedic Surgery Clinic
1801 Inwood Rd
Dallas, TX 75390-8882
Phone: 214-645-3300 Fax: 214-645-3301

SUPPLIES ORDER

FIN #: Epic Visit #: 726291007

Patient Name: BLACK,CHARMERIA MRN: 96288520 DOB: 06/12/1983
Address: 432 Round Rock Rd Sex: Female Hm ph: no phone
Cedar Hill, TX 75104-5428 Wk ph:

Primary Visit Diagnosis: Contusion of right foot, initial encounter [S90.31XA]
Other Visit Diagnosis: Sprain of anterior talofibular ligament of right ankle, initial encounter [S93.491A]

Order: DME SUPPLY OR ACCESSORY, NOS [ID:A9999 HCPCS: A9999] Order #: 633495478
Priority: Routine Class: Normal
Comment:dispense 1: a rebound air walker (medium) was prescribed to stabilize the patients ankle to allow the ankle to heal
Associated Diagnoses
S90.31XA Contusion of right foot, initial encounter
S93.491A Sprain of anterior talofibular ligament of right ankle, initial encounter

Order Date:05/08/2025
Ordering User:ENRIQUEZ, ELISABETH
Authorizing Provider:Skiles, Steven Leo [UPIN:]
Department:ORTHOPAEDIC SURGERY

UT Southwestern Medical Center

Appointment:	**4/28/25 2:40 PM CDT**
MRN:	**96288520**
Guarantor:	**Charmeria Black**
Confidential Patient:	
Study Patient:	

ENCOUNTER

Patient Class:	**Ambulatory**	Provider:	**Steven Leo Skiles**
Visit Type:	**NEW TO MD**	Ref Phy:	**Raspovic, Katherine Marie, DPM**
Clinic Name:	**Orthopaedic Surgery Clinic**		

PATIENT

Name:	**BLACK, CHARMERIA**	DOB:	**6/12/1983 (41 yrs)**
Address:	**432 Round Rock Rd Cedar Hill TX 75104-5428**	Sex:	**Female**
Marital Status:	**Divorced**	SSN:	xxx-xx-3866
Email:	**chameria31@gmail.com**	Patient Primary	**214-791-5345**
Prim Care Prov:	**Siddiqi, Humza Feroz, MD**		

EMERGENCY CONTACT

Contact Name	Legal Guardian?	Relationship to Patient	Home Phone	Work Phone
1. Holmes,Michael		**PHI Designee**	**(214)796-4366**	
2. Henderson,ZaKayla		**Daughter**		

GUARANTOR

Guarantor:	**CHARMERIA BLACK**	DOB:	**6/12/1983**
Address:	**432 Round Rock Rd**	Sex:	**Female**
	CEDAR HILL, TEXAS 75104-5428		
Rel to Pat:	**Self**	Hm Phone:	**NO PHONE**
Guar ID:	**5921555**	Wk Phone:	

GUARANTOR EMPLOYER

Employer:		Status	**FULL TIME**

COVERAGE

PRIMARY INSURANCE

Payor:	**AETNA U.S. HEALTHCARE**	Plan:	**AETNA HEALTH PLANS OF**
Group Number:	**014193801000100**	Insurance Type:	**PPO**
Subscriber Name:	**BLACK,CHARMERIA**	Subscriber DOB:	**6/12/1983**
Subscriber ID:	**W257398296**	Insurance Addr:	**PO BOX 981106**
Member ID:	**W257398296**	Insurance Phone:	**800-441-8664**
Pat. Rel To Subscr:	**Self**	Insurance Auth:	**800-441-8664**
Eff From Date:	**1/1/2020**	Eff To Date:	

SECONDARY INSURANCE

Payor:		Plan:	
Group Number:		Insurance Type:	
Subscriber Name:		Subscriber DOB:	
Subscriber ID:		Insurance Addr:	
Member ID:		Insurance Phone:	
Pat. Rel. To Subscr:		Insurance Auth:	
Eff From Date:		Eff To Date:	

Black, Charmeria

MRN: 96288520

Office Visit 4/28/2025
Orthopaedic Surgery Clinic

Provider: Skiles, Steven Leo, PA-C (PA: Orthopaedic Surgery (20))
Primary diagnosis: Contusion of right foot, initial encounter
Reason for Visit: Referred by Raspovic, Katherine Marie, DPM

Progress Notes

Skiles, Steven Leo, PA-C (Physician Assistant) • PA: Orthopaedic Surgery (20)

FOLLOW UP VISIT: 4/28/2025

HISTORY OF PRESENT ILLNESS:
Charmeria Black is a very pleasant 41-year-old female who is a patient of Dr. Raspovic and presents today for evaluation of her right ankle. She has undergone a previous ATFL/CFL ligament repair on 12/19/2022. She was doing well up until 2 days ago when she stepped off a curb and suffered a inversion injury. She noted immediate pain and swelling at that time. She is unable to weight-bear in the clinic today.

PHYSICAL EXAMINATION:
Blood pressure (!) 166/109, pulse 109, not currently breastfeeding.
in no apparent distress and well developed and well nourished
The patient is unable to weight-bear across her right lower extremity at today's visit. Inspection of her right ankle shows 2+ pitting edema and ecchymosis over the lateral malleoli and extending into her foot. She has exquisite tenderness over the ATFL and CFL. She is able to plantarflex and dorsiflex. Unable to perform stress testing secondary to pain. 1+ dorsalis pedis pulse. She has intact EHL/FHL as they move her lesser toes.

RADIOGRAPHIC STUDIES:
3 views of the right ankle show no acute or subacute osseous abnormalities. The mortise is intact. Lucency with noted within the distal fibula questionable previous screw hole from surgical intervention in the past.
3 views of the right foot were also obtained for today's visit which show hallux valgus deformity. Pes planus deformity is noted on the lateral view. No significant midfoot arthrosis noted. Interosseous lucency noted within the distal phalanx of the hallux.

IMPRESSION:
Status post right ATFL/CFL ligament repair with recent inversion injury

PLAN:
Exam findings and x-rays reviewed with her. At this time, I would like to put her into a walking boot. She may weight-bear as tolerated. She was instructed on icing and elevation. She is provided a prescription for meloxicam 15 mg to be taken on a daily basis for next 2 weeks. Side effects and interactions reviewed with her. I would like to have her either see myself or Dr. Raspovic in 2 weeks for repeat evaluation. If she is no better, or worse, I will go ahead and obtain a repeat noncontrast MRI of her right ankle to ensure that her repair is stable. All of her questions were invited and answered fully. She is in agreement with this treatment plan.

Greater than 35 minutes was spent with the patient today on pre-visit planning, reviewing medical history, imaging, laboratory results, face-to-face encounter, education, referrals/care coordination, and documentation of today's visit

Steven Skiles, MPAS, PA-C

This document was dictated using Dragon voice recognition software.
Occasional spelling, and punctuation errors may occur.

Answers submitted by the patient for this visit:
Review of Systems (Submitted on 4/28/2025)
Fever: No
Chills: No
Weight Loss: No
Weight Gain: No
Fatigue: No
Sweating: No
Night Sweats: Yes
General Weakness: No

Hot flashes: Yes
Rash: No
Itching: No
Change in mole(s): No
Unusual Hair Loss: No
Breast concerns: No
Headaches: No
Difficulty Hearing: No
Ringing in the Ears: No
Ear Discharge: No
Ear Pain: No
Nosebleeds: No
Sinus/Nasal Congestion: No
Loss of smell: No
Snoring: No
Difficulty Swallowing: No
Sore Throat: No
Mouth Lesions: No
Dry Mouth: No
Sore Mouth: No
Fever Blisters: No
Blurred Vision: No
Double Vision: No
Pain Looking at Bright Lights: No
Eye Pain: No
Eye Discharge: No
Eye Redness: No
Dry Eyes: No
Chest Pain: No
Palpitations: No
Leg or Ankle Swelling: No
Sudden shortness of breath during sleep: No
Difficulty Breathing When Lying Flat: No
Cough: No
Coughing Blood: No
Sputum Production: No
Shortness of Breath: No
Wheezing: No
Stridor: No
Pain with breathing: No
Heartburn: No
Change In Appetite: No
Nausea: No
Vomiting: No
Abdominal Pain: No
Diarrhea: No
Constipation: No
Blood in Stool: No
Black Stool: No
Incontinence of Stool: No
Urgency to Urinate: No
Blood in Urine: No
Pain When Urinating: No
Vaginal Discharge: No
Frequency in Urination: No
Incontinence of Urine: No
Sexual Problems: No

Do you have any vaginal discomfort or concerns?: No
Muscle Pain: Yes
Neck Pain: No
Back Pain: No
Joint Pain: Yes
Falls: Yes
Environmental Allergies: No
Seasonal Allergies: No
Frequent Thirst: No
Heat Intolerance: No
Cold Intolerance: No
Easy Bruising / Bleeding: Yes
Dizziness: No
Tremor: No
Numbness or Tingling: No
Speech Change: No
Loss of Limb Strength: No
Seizures: No
Loss of Consciousness: No
Substance Abuse: No
Hallucinations: No
Nervous / Anxious: No
Insomnia: No
Memory Loss: No
Depression: No
Suicidal Ideas: No

Other Notes

All notes

Addendum Note from Skiles, Steven Leo, PA-C (PA: Orthopaedic Surgery (20))

Progress Notes from Enriquez, Elisabeth, CMA

Instructions

After Visit Summary (Automatic SnapShot taken 4/28/2025)

Additional Documentation

Vitals: BP 166/109 ! (Abnormal) (BP Site: Upper Arm, Left) Pulse 109

Flowsheets: Patient Identified, Vitals, Vitals

Communications

Letter sent to Katherine Marie Raspovic, DPM

Sent 4/29/2025

Orders Placed

XR ANKLE RIGHT 3 VIEWS (Resulted 4/28/2025)
XR FOOT RIGHT 3 VIEWS (Resulted 4/28/2025)
MR ANKLE RIGHT WO IV CONTRAST
DME SUPPLY OR ACCESSORY, NOS

Medication Changes

As of 4/28/2025 3:35 PM

	Refills	Start Date	End Date
Added: meloxicam (MOBIC) 15 mg oral tablet Take 1 Tablet (15 mg total) by mouth daily - Oral	0	4/28/2025	—

Medication List at End of Visit

As of 4/28/2025 3:35 PM

	Refills	Start Date	End Date
acetaminophen (TYLENOL) 325 mg oral tablet Take 650 mg by mouth - Oral Patient-reported medication	—	4/27/2025	5/2/2025
acetaminophen-codeine (TYLENOL #3) 300-30 mg oral tablet Take 1 Tablet by mouth every 6 hours as needed for Pain Max of 3000 mg acetaminophen/24hrs (all sources). - Oral	0	3/25/2025	—
amLODIPine (NORVASC) 10 mg oral tablet Take 1 Tablet (10 mg total) by mouth daily - Oral	3	2/14/2025	—
buPROPion XL (WELLBUTRIN XL) 300 mg 24 hr oral tablet Take 1 Tablet (300 mg total) by mouth every morning - Oral	3	4/4/2025	—
meloxicam (MOBIC) 15 mg oral tablet Take 1 Tablet (15 mg total) by mouth daily - Oral	0	4/28/2025	—
NIFEdipine XL (PROCARDIA XL) 30 mg 24 hr oral tablet Take 30 mg by mouth daily - Oral Patient-reported medication	—	8/16/2024	—
nitrofurantoin, macrocrystal-monohydrate, (MACROBID) 100 mg oral capsule Take 100 mg by mouth - Oral Patient-reported medication	—	11/10/2024	—
ondansetron (ZOFRAN ODT) 4 mg rapid dissolve oral tablet Take 1 Tablet (4 mg total) by mouth every 8 hours as needed for Nausea or Nausea/Vomiting - Oral	4	3/31/2025	—
ondansetron (ZOFRAN) 4 mg oral tablet TAKE 1 TABLET(4 MG) BY MOUTH TWICE DAILY	3	4/5/2024	—
promethazine HCl			
promethazine (PHENERGAN) 50 mg rectal suppository Insert 1 Suppository (50 mg total) rectally every 6 hours as needed for Nausea - Rectal	3	4/8/2024	—
promethazine (PHENERGAN) 12.5 mg oral tablet Take 1 Tablet (12.5 mg total) by mouth every 6 hours as needed for Nausea - Oral	2	3/31/2025	—
QUEtiapine (SEROQUEL) 25 mg oral tablet Take 1 Tablet (25 mg total) by mouth at bedtime - Oral Notes to Pharmacy: Switching pt to seroquel for insomnia and mood augmentaiton. Please stop abilify and trazodone.	3	4/4/2025	—

Visit Diagnoses

Primary: **Contusion of right foot, initial encounter** S90.31XA
Sprain of anterior talofibular ligament of right ankle, initial encounter S93.491A

Current Clinic-Administered Medications

None