TRI-COUNTY ORTHOPEDICS

197 Ridgedale Avenue, Suite 300
Cedar Knolls, NJ 07927
Phone: 973-538-2334

Office Visit Summary

Exam Date: 3/7/23 Date of Injury: 02/28/2023 Physician: DAVID EPSTEIN, MD

Patient: ALISA BARNES Carrier: D&H Clm#: PLB083015

Adjustor: ANGELA MONTGOMERY Phone: 973-940-1851 Ext:241

Email: AMONTGOMERY@RISKSOLUTIONS.COM Fax:973-940-1852

Case Mgr/Other: Phone: Ext:

Email: Fax:

Diagnosis: (L) Ankle Distal Fibula Fx

ICD-10: (Ankle) Causality: (first visit only) Yes X No

Work Status

Unable to work effective: 3/7/23 Return to work full duty effective: _____

Return to work with modifications: _____

Restrictions include: ☐ No Climbing ☐ No Kneeling ☐ No Squatting ☐ No Overhead lifting

Maximum lift and push/pull of _____ lbs with affected extremity

NWB TTWB PWB FWB No use of: _____ Other: _____

Able to drive at work: Yes_____ No_____ Estimated MMI: _____

Able to drive outside of work: Y/N _____

Treatment Plan

Physical Therapy: 2-3 x/wk 4 wk ☐ MRI/MRI Arthrogram ☐ CT Scan

☐ Injection ☐ EMG/NCS ☐ Brace ☐ Splint ☐ CAM Walker

☐ HEP/Therabands ☐ Consults _____

☐ Other Ultrasound 2 wk

Medications

Narcotic prescribed: _____ Start Date: _____

Pain Score prior to narcotic initiation: (0-10)____ Pain Score after Narcotic initiation (0-10)_____

Referral to pain management: _____

Follow up appointment: March 21st @ 3:45 AM/PM MMI: ☐ Yes ☐ No

TCO Case Manager: _____ Ext: _____

2 wk

Orthopedic Surgeon

ARMAC
ORTHOTICS · PROSTHETICS · CPM

ASSIGNMENT OF BENEFITS

HOURS: Monday–Friday 8AM–5PM
After Hours Technician, call 888.422.3044
(hit option 1 to leave a full-detailed message for our on-call technician)

#_____ An authorization/precert # does not guarantee payment by the insurance carrier

PRESCRIPTION

REF 79-95525 SN 00018
XCELTRAX® AIR ANKLE, MEDIUM

Doctor Name: David Epstein, MD
Date of Injury: 2/28/23 Required for: ☒ WC ☐ NF
Product Description: Short boot
Patient Diagnosis ICD-10 Code #: S93.402
Size: medium ☐ Right ☒ Left Limb: ankle ☐ Rental ☐ Purchase ☒

The prescribed product is medically indicated and in my opinion is reasonable and necessary with reference to the accepted standards of medical practice and treatment of this patient's condition.

**DOCTOR'S SIGNATURE: David Epstein Date: 3/7/23 S/N:

PATIENT NAME: Alisa Barnes Email Address:
Address: City: State: Zip:
☐ Male ☒ Female **Date Of Birth:** 6/7/69 Primary Phone #: ☐ H ☐ W ☐ C

PRIMARY INSURANCE (ATTACH or FILL IN)

Subscriber Name: Date of Birth: Relationship:
Insurance Company Name: WC - D + H Alternative Risk Soln Policy #: Group #:
Insurance Address: W/C #:

SECONDARY INSURANCE (ATTACH or FILL IN)

Subscriber Name: Date of Birth: Relationship:
Insurance Company Name: Policy #: Group #:
Insurance Address: W/C #:

ASSIGNMENT OF BENEFITS

I have received the above product as prescribed by my physician. I authorize my physician to release to ARMAC Inc and for ARMAC to release to my insurer any needed information for this or a related claim. I request that payment of authorized benefits be made on my behalf, and I assign the benefits payable for the medical equipment provided by ARMAC or its affiliates. Although I recognize that I have the primary responsibility for contracting and submitting claims to my insurer, I have received the equipment and authorize ARMAC to submit a claim to any of the insurers as may be required. I understand that I am responsible for deductibles and co-insurance not covered by my insurance. Should my insurance plan not provide coverage in its entirety for any reason, I understand that I may be responsible for payment.

I was hereby given advanced notice that **Medicare and other insurance companies do not pay for cold therapy products, slings, rib belts, post-op shoes, cast boots, insoles/shoe inserts, heel cups, wedges/pads, arch supports, elbow protectors, elastic supports, and surgical stockings. I understand that because these items are excluded from Medicare and other insurance coverages, therefore I am responsible for payment to ARMAC.**

☐ If I am renting **CPM** equipment, I understand that Medicare will only cover CPM treatment for total knee replacement. Use of this device must commence within two days following surgery and is limited to the three-week period following surgery during which the device is used in my home.
When finished with rental unit, please call ARMAC for pick up, 888.422.3044

Waiver of liability: I agree to relinquish and hold harmless ARMAC Inc. and their agents from any damages of losses sustained arising from improper use of the above unit.

I have received: Copy of assignment of benefits, my HIPAA information, patient rights and supplier standards and have been instructed about my product. I also understand my rights and the supplier's responsibilities that if I have any questions, concerns, complaints or issues about my product, I can call ARMAC. I have done a return demonstration and have been given instructions on and understand how to use and take care of this product. I know that I should contact my physician if my health condition changes.

I authorize my physician and surgery center to release to ARMAC Inc, and for ARMAC Inc to release to my insurer, any needed information to this or a related claim.

**** Patient / Authorized Signature:** [signature] **Date:** 3/7/23 **Technician:** [signature]

Your signature on this form indicates that you have received the prescribed product and paperwork, and that you understand the documents and training for use of the product.

Check #: _____ (payable to ARMAC Inc.) Your Insurance Requires a Copay:

Cardholder: Card #: Exp. Date:
☐ Visa ☐ Mastercard ☐ AMEX ☐ Discover

Cardholders Signature: Amount: 3 Digit Pin (back of card):

TRI-COUNTY ORTHOPEDICS

World-Class Team. Hometown Choice.

David Epstein M.D.
PO BOX 1446, Morristown, NJ 07962-1446 Main: 973-538-2334 Billing: 973-538-0329

☐ 197 Ridgedale Ave, 3rd floor
Cedar Knolls, NJ 07927
Fax: 973-267-6882 (Sport)
Fax 973-538-4081 (Joint)

☒ 1590 Route 206
Bedminster, NJ 07921
Fax:908-234-2022

☐ 757 Route 15
Lake Hopatcong, NJ 07849

FOOT & ANKLE PHYSICAL THERAPY PRESCRIPTION:

Patient Name: **Alisa Barnes** Date: **3-7-2023**
Diagnosis: ☐ Right ☒ Left ☐ Bilateral Frequency: ☒ 2-3x/week Duration: ☒ 4 wks ☐ 6 wks
S93.402ASprain of unspecified ligament of left ankle, init encntr Left ankle sprain and distal fib avulsion fx

☐ **Continue as per initial protocol**

MODALITIES:

☒ Modalities as needed
☐ Cryo-therapy
☐ Aqua-therapy
☐ Ultrasound
☐ Whirlpool
☐ Sensory Re-education & Desensitization
☐ Moist Heat
☐ Massage
☐ NMES
☐ TENS
☐ Soft Tissue Manipulation
☐ Scar Management
Local Wound Care

WEIGHT BEARING: ☐ NWB ☐ PWB ☐ WBAT

EDEMA CONTROL:

☐ Edema Control Techniques
☐ Compression Stocking
Jobst Stocking
☐ Coban
☐ Elastic Wrap

PRECAUTIONS:

☐ No Pivoting
☐ No Cutting
☐ No Twisting
☐ No Jumping
☐ No Heavy Squatting
☐ Minimize Impact Loading

ANKLE/FOOT EXERCISE:

☒ AROM (Limits: _____)
☒ AAROM (Limits: _____)
☒ PROM (Limits: _____)
☒ Gait Training ☒ ADL's
☒ Babst Board Exercises (Platform Roller Ball)
☒ Plantar Fascia Stretching (Can Rolling- Under Foot)
☒ Proprioceptive Training
- ☐ Foam Cushion (Standing Single Leg Balance)
- ☐ "Toe Grabs" (Pick up/Move Objects)
- ☐ Single Leg Toe & Heel Raises

☒ Core LE Strengthening & Endurance Program
- ☐ Closed Chain ☐ Open Chain
- ☐ (Patient Education / Home Exercises)

☐ Return to Sport Specific Exercise/Training Activity

SPECIAL REHABILITATION PROGRAMS:

☐ Agility & Plyometric Exercises
☐ Peroneal Strengthening
☐ Achilles Stretching/Strengthening
- ☐ Eccentric Exercises
- ☐ Patient Education/Home Program

☐ Kinetic Chain/ Core Strengthening
- ☐ Theraband Resistance Exercises
- ☐ Corrective Exercises – LE Mechanical Alignment

BRACING/EQUIPMENT/SUPPLIES:

☐ CAM Walking Boot [☐ Low - ☐ High]
☐ Air-Cast Ankle Splint ☐ Lace-Up Ankle Brace ☐ Heel Lift (Wedge/Gel Cup)
☐ Orthotic Shoe Insert [☐ Hard Sole ☐ Medial Arch Support ☐ Lateral Post ☐ Metatarsal Pad]
☐ Custom Orthotic: _____

Physician's Signature: _____
(I have medically prescribed the above treatment)

David M. Epstein, MD
Sports Medicine & Orthopedic Surgery
Shoulder, Knee, Foot & Ankle Surgery

Please send progress notes

TRI-COUNTY ORTHOPEDICS

World-Class Team. Hometown Choice.
PO BOX 1446, Morristown, NJ 07962-1446
(973) 538-2334

Mar 7, 2023

Patient Name: Alisa Barnes

The above named patient has been under my care for an orthopedic problem.

☒ Had an appointment today 3/7/23

☒ Work guidelines: _____

☐ No Work: **3/7/23**

☐ Return to Full Duty: _____

☐ Light Duty: _____

☐ Limitations: _____

_____

_____

If there are any questions, please feel free to contact our office.

Sincerely,

_____

Physician Name: David Epstein M.D.