Patients Care Medical Supply
Patient Admission Packet

Patient: M|SITE.SHIP_TO_NAME

Patient ID: M|CUSTOMER.PATIENT_ID

Address: M|SITE.SHIP_TO_ADDRESS|M M|SITE.SHIP_TO_CITY, M|SITE.SHIP_TO_STATE M|SITE.SHIP_TO_ZIP

Phone: M|SITE.SHIP_TO_PHONE_NUMBER

AUTHORIZATIONS: I hereby authorize and consent to the provision of products and/or services to me by Patients Care Medical Supply. I understand that I am under the control of my physician and that Patients Care Medical Supply is not liable for any act or omission when following the instructions of said physician. I authorize Patients Care Medical Supply to contact me via mail, email or phone to inform me of special programs/sales related to or a logical adjunct of the products I have received.

PHI: I authorize the release/disclosure of my Protected Health Information (PHI)--any records pertaining to my medical history for products or services rendered--to be reviewed by Patients Care Medical Supply, the Centers for Medicare and Medicaid Services, my insurance carrier or other healthcare entities/providers involved in my care for purposes of determining benefits, processing a claim for payment, performance improvement, accreditation, certification, licensing or if required by federal, state or local law. Patients Care Medical Supply may disclose my PHI to family or friends involved in my care, unless I refuse in writing. ***(See our Privacy Notice for full list of disclosures.)***

ASSIGNMENT OF BENEFITS: I authorize direct payment of Medicare, Medicaid, insurance and any other healthcare benefits to Patients Care Medical Supply for authorized services/equipment furnished to me by Patients Care Medical Supply. In the event payments for insurance benefits are made directly to me on an assigned claim, I will endorse all checks for such payments or otherwise reimburse Patients Care Medical Supply the amount due.

AGREEMENT TO PAY / FINANCIAL RESPONSIBILITY: All insurance verifications of coverage are based on plan provisions, and are not a guarantee of benefits. Patients Care Medical Supply will submit your claim, but it remains your responsibility to make sure the claim is paid. We strongly recommend that you contact your insurance company to discuss your plan provisions and coverage. While insurance or other coverage may exist for the equipment provided to me by Patients Care Medical Supply, I understand that not all equipment may be covered, or that reimbursement may be less than 100% of billed charges in accordance with my coverage. **Therefore, I agree to be financially responsible for any balance owed on my account including co-payments, coinsurance and deductibles, or even the full amount if the insurance company denies or recoups payment for services/equipment originally thought to be covered. Prior to receiving products, Patients Care Medical Supply requires a form of payment on file to satisfy any balances that are not paid by your insurance. This will include that patient portion of rental charges incurred in future months.** I understand that if I fail to notify Patients Care Medical Supply immediately of a change in insurance carrier, and charges are not paid by the new carrier due to timely filing criteria, I will be financially responsible for the full amount not paid. Outstanding charges are due within 15 days from date of billing statement. Unpaid accounts will be sent to collections, with collection costs charged to the patient/legal agent.

RENTAL AGREEMENT: I understand that if I am renting equipment from Patients Care Medical Supply, the rented equipment remains the property of Patients Care Medical Supply, ownership will not be transferred until all amounts due Patients Care Medical Supply are fully paid, and that the equipment must remain within the service area unless written permission is given and documented by Patients Care Medical Supply. I agree that if after reasonable notice I fail to pay any charge when due, Patients Care Medical Supply may in addition to all other remedies which may be available, peaceably repossess the equipment without legal process. I agree not to remove or alter any identification on the equipment or in way attempt to transfer such equipment. Following the rental term, Patients Care Medical Supply will extend a three-day grace period for the return of monthly rentals and a one-day grace period for weekly rentals. Full rental charges will be incurred after the grace period. **If you enter a hospital, nursing home or hospice care, or no longer medically need the rented equipment, you must notify Patients Care Medical Supply immediately. Medicare, Medicaid and most insurance plans do not cover medical equipment while you are in the hospital, nursing home or under hospice care.**

RETURN POLICY: Returns are accepted only within 3 days of purchase with the original receipt, in the original, unopened, and undamaged packaging. Products are **NOT RETURNABLE** if modified, used, custom-made, for

personal care or worn against the body. If the third day falls on a weekend or holiday, we will honor the return on the next open business day. Home medical equipment that is rented will be returned after the practitioner has discontinued service. Patients Care Medical Supply must be notified within 24 hours of the set-up if any equipment is defective. In the case of defective equipment, an exchange will be made for the defective item.

WARRANTY POLICY: Equipment that is rented or purchased may have a manufacturer's warranty that varies with each item and manufacturer, Patients Care Medical Supply will uphold the manufacturer's warranty coverage and we will honor all warranties under applicable law. Patients Care Medical Supply for items not in a rental period, the patient will be responsible for expenses such as labor, shipping, delivery and/or travel time. These are not covered under the warranty. Additionally, if available, an owner's manual with warranty information will be provided to beneficiaries for all durable medical equipment.

COVENANTS: This document represents the entire agreement between the parties and supersedes all prior oral and/or written agreements and representations. No provision of this agreement may be waived or modified, unless in writing and signed by Patients Care Medical Supply. I agree this agreement will be binding on my heirs, representatives and assignees. I certify that all patient information provided to Patients Care Medical Supply is true, complete and accurate. Note: a copy of this Agreement and Consent shall be considered the same as the original, and all authorizations will remain in effect until revoked in writing.

GRIEVANCE / COMPLAINT REPORTING: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. We will not retaliate against you for filing a complaint. Please call 337-989-0005 and speak to the Customer Service Supervisor. If your complaint is not resolved to your satisfaction within five working days, you may initiate a formal grievance in writing. To initiate a formal grievance please notify our Privacy Contact, in writing, at the following address: 8907 Maurice Ave, Maurice, LA 70555. You can expect a written response within fourteen working days or receipt.

You may also file a complaint with the Secretary of the U. S. Department of Health and Human Services in writing at the following address: 200 Independence Ave. S.W., Washington D.0 20201.

To make inquiries or complaints about this company by calling Medicare; 1-800-MEDICARE and/or the Accreditation Commission for Health Care (ACHC); 919-785-1214.

I hereby certify that: I am the patient/beneficiary, or am duly authorized to execute this Agreement and accept its terms on behalf of the patient; I have been given an opportunity to read this document, understand its terms and conditions, and have received a copy thereof; I have received, or been offered and declined, the Medicare Supplier Standards, Patient Rights/Responsibilities, Privacy Notice and Scope of Services. I consent to the release of my PHI as needed for the purposes of treatment, payment, legal requirements and healthcare operations.

PATIENT BILL OF RIGHTS AND RESPONSIBILITIES
We believe that all patients receiving services from Patients Care Medical Supply should be informed of their rights.

1. Be fully informed in advance about care/service to be provided, including the disciplines that furnish care and the frequency of visits, as well as any modifications to the plan of care.
2. Be informed, both orally and in writing, in advance of care being provided, of the charges, including payment for care/service expected from third parties and any charges for which the client/patient will be responsible.
3. Receive information about the scope of services that the organization will provide and specific limitations on those services.
4. Participate in the development and periodic revision of the plan of care.
5. Refuse care or treatment after the consequences of refusing care or treatment are fully presented.
6. Be informed of client/patient rights under state law to formulate an Advanced Directive, if applicable.
7. Have one's property and person treated with respect, consideration, and recognition of client/patient dignity and individuality.
8. Be able to identify visiting personnel members through proper identification.
9. Be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of client/patient property.
10. Voice grievances/complaints regarding treatment or care, lack of respect of property or recommend changes in policy, personnel, or care/service without restraint, interference, coercion, discrimination, or reprisal.

11. Have grievances/complaints regarding treatment or care that is (or fails to be) furnished, or lack of respect of property investigated.
12. Confidentiality and privacy of all information contained in the client/patient record and of Protected Health Information .
13. Be advised of the agency's policies and procedures regarding the disclosure of clinical records.

14. Choose a health care provider, including choosing an attending practitioner, if applicable.
15. Receive appropriate care without discrimination in accordance with practitioner orders, if applicable.
16. Be informed of any financial benefits when referred to an organization.
17. Be fully informed of one's responsibilities.

PATIENT RESPONSIBILITIES

1. Patient agrees that rental equipment will be used with reasonable care, not altered, or modified, and returned in good condition (normal wear and tear excepted).
2. Patient agrees to promptly report to Patients Care Medical Supply any malfunctions or defects in rental equipment so that repair/ replacement can be arranged.
3. Patient agrees to provide Patients Care Medical Supply with access to all rental equipment for repair/replacement, maintenance, and/or pick-up of the equipment.
4. Patient agrees to use the equipment for the purposes so indicated and in compliance with the practitioner's prescription.
5. The patient agrees to keep the equipment in their possession and at the address to which it was delivered unless otherwise authorized by Patients Care Medical Supply
6. Patient agrees to notify Patients Care Medical Supply of any hospitalization, change in customer insurance, address, telephone number, practitioner, or when the medical need for the rental equipment no longer exists.
7. Patient agrees to request payment of authorized Medicare, Medicaid, or other private insurance benefits to be paid directly to Patients Care Medical Supply for any services furnished by Patients Care Medical Supply
8. Patient agrees to accept all monetary responsibility for home medical equipment furnished by Patients Care Medical Supply
9. Patient agrees to pay for the replacement cost of any equipment damaged, destroyed, or lost due to misuse, abuse or neglect.
10. Patient agrees not to modify the rental equipment without the prior consent of Patients Care Medical Supply
11. Patient agrees that any authorized modification shall belong to the titleholder of the equipment unless the equipment is purchased and paid for in full.
12. Patient agrees that title to the rental equipment and all parts shall remain with Patients Care Medical Supply always unless equipment is purchased and paid for in full.
13. Patient agrees that Patients Care Medical Supply shall not insure or be responsible to the patient for any personal injury or property damage related to any equipment; including that caused by use or improper functioning of the equipment; the act or omission of any other third party, or by any criminal act or activity, war, riot, insurrection, fire, or act of God.
14. Patient understands that Patients Care Medical Supply retains the right to refuse delivery of service to any patient at any time.
15. Patient agrees that any legal fees resulting from a disagreement between the parties shall be borne by the unsuccessful party in any legal action taken.

When the patient is unable to make medical or other decisions, the family should be consulted for direction.

Medicare DMEPOS Supplier Standards
The products and/or services provided to you by (Patients Care Medical Supply) 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 with a written copy of the standards.

Medicare Capped Rental and Inexpensive or Routinely Purchased Items

Capped Rental Items *(not eligible under Medicare for outright purchase)*

Medicare will pay a monthly rental fee for a period not to exceed 13 months after which ownership of the equipment is transferred to the Medicare beneficiary. After ownership of the equipment is transferred to the Medicare beneficiary; it is the beneficiary's responsibility to arrange for any required equipment service or repair. These items will be identified as a rental on your delivery ticket.

These items include (but are limited to):

- Basic Manual Wheelchairs
- Tilt in Space and Pediatric Manual Wheelchairs
- Standard Power Wheelchairs
- Standard Power Wheelchair accessories/replacement parts (Vent Trays, Electronics and joysticks)
- Power Assist Wheels
- Hospital Beds
- Alternating Pressure Pads
- Air-fluidized Beds
- Nebulizers
- Suctions Pumps
- Continuous Airway Pressure (CPAP/BIPAP) Devices
- Patient Lists
- Trapeze bars

Oxygen equipment is rented for 36 months, at which time the equipment is considered capped but remains the property of Patients Care Medical Supply. We will maintain it for the next 24 months. After 60 months, Patients Care Medical Supply will replace equipment if necessary or at beneficiary's request and begin a new rental period.

Inexpensive or Routinely Purchased Items

Equipment in this category can be purchased or rented; however, the total amount paid for monthly rentals cannot exceed the fee schedule purchase amount.

These items include *(but are not limited to):*

- Canes
- Walkers
- Crutches
- Commodes
- Low Pressure and Position Equalizing Pads
- Blood Glucose Monitors
- Seat Lift Mechanisms
- Pneumatic Compressors (Lymphedema-Pumps)
- Bed Side Rails
- Complex Power Wheelchairs
- Powered Seating items provided for Complex Power Wheelchairs
- Complex Power Wheelchair accessories (Vent Tray, Electronics and joystick controllers)
- Complex Power Wheelchair service and replacement parts
- Custom Manual Wheelchairs

For the items provided that I have the option of renting or purchasing I select:

○ Purchase Option ○ Rental Option

HIPAA Notice of Privacy Practices ("Notice")

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. IT FURTHER DETAILS HOW YOU OR YOUR PERSONAL REPRESENTATIVE MAY GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

If you have any questions about this Notice please contact our **Privacy Contact**. This Notice describes how our practice and health care professionals, employees, volunteers, trainees and staff may use and disclose you medical information to carry out treatment, payment or health care operations and for other purposes that are described in this Notice. We understand that medical information about you and your health is personal and we are committed to protecting medical information about you. This Notice applies to all records of your care generated by this practice.

This Notice also describes your right to access and control your medical information. This information about you includes demographic information that may identify you and that relates to your past, present and future physical or mental health or condition and related health care services. Typically your medical information will include symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment.

We are required by law to protect the privacy of your medical information and to follow the terms of this Notice. We may change the terms of this Notice at any time. The new Notice will then be effective for all medical information that we maintain at that time and thereafter. We will provide you with any revised Notice if you request a revised copy be sent to you in the mail or if you ask for one when you are in the office.

I. **Uses and Disclosures of Protected Health Information**
Your medical information may be used and disclosed for purposes of treatment, payment and health care

operations. The following are examples of different ways we use and disclose medical information. These are examples only.

a. **Treatment**
We may use and disclose medical information about you to provide, coordinate, or manage your medical treatment or any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your medical information. For example, we could disclose your medical information to a home health agency that provides care to you. We may also disclose medical information to other physicians who may be treating you, such as a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your medical information to another physician or health care provider, such as a laboratory.

b. **Payment**
We may use and disclose medical information about you to obtain payment for the treatment and services you receive from us. For example, we may need to provide your health insurance plan information about your treatment plan so that they can make a determination of eligibility or to obtain prior approval for planned treatment. For example, obtaining approval for a hospital stay may require that relevant medical information be disclosed to the health plan to obtain approval for the hospital admission.

c. **Healthcare Operations**
We may use or disclose medical information about you in order to support the business activities of our practice. These activities include, but are not limited to, reviewing our treatment of you, employee performance reviews, training of medical students, licensing, marketing and fundraising activities and conducting or arranging for other business activities.

For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may call you by name in the waiting room when your physician is ready to see you. We may user or disclose your medical information to remind you of your next appointment.

We may share your medical information with third party "business associates" that perform activities on our behalf, such as billing or transcription for the practice. Whenever an arrangement between our office and a business associate involves that use or disclosure of your medical information, we will have a written contract that contains terms that asks the "business associate" to protect the privacy of your medical information.

We may use or disclose your medical information to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your medical information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you.

We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Contact to request that these fundraising materials not be sent to you.

d. **Healthcare Operations**
We, along with certain other health care providers and practice groups in the area, may participate in a health information exchange ("Exchange"). An Exchange facilitates electronic sharing and exchange of medical and other individually identifiable health information regarding patients among health care providers that participate in the Exchange. Through the Exchange we may electronically disclose demographic, medical, billing and other health-related information about you to other health care providers that participate in the Exchange and request such information for purposes of facilitating or providing treatment, arrangement for payment for health care services or otherwise conducting or administering health care operations.

II. **Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object.**
We may use and disclose your medical information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your medical information. If you are not present or able to agree or object to the use or disclosure of the medical information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the medical information that is relevant to your health care will be disclosed.

a. **Others Involved in Your Healthcare:**
Unless you object, we may disclose to a member of your family, a relative, or a close friend your medical information that directly related to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information if we determine that it is in your best interest based on our professional judgment. We may use or disclose medical information to notify or assist in notifying a family member or any other person that is responsible for your care of your location, general condition or death.

Finally, we may use or disclose your medical information to an entity assisting in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

b. **Emergencies:**
We may use or disclose your medical information for emergency treatment. If this happens, we shall try to obtain your consent as soon as reasonable after the delivery of treatment. If the practice is required by law to treat you and has attempted to obtain your consent but is unable to do so, the practice may still use or disclose your medical information to treat you.

c. **Communication Barriers::**
We may use and disclose your medical information if the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and, in our professional judgment, you intended to consent to use or disclose under the circumstances.

III. **Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object.**
We may use or disclose your medical information in the following situations without your consent or authorization. These situations include:

a. **Required By Law:**
We may use or disclose your medical information when federal, state or local law requires disclosure. You will be notified of any such uses or disclosure.

b. **Public Health:**
We may disclose your medical information for public health activities and purposed to a public health authority that is permitted by law to collect or receive the information. This disclosure will be made for the purpose of controlling disease, injury or disability.

c. **Communicable Diseases**
We may disclose your medical information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk or contracting or spreading the disease or condition.

d. **Health Oversight:**
We may disclose your medical information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections and licensure. These activities are necessary for the government agencies to oversee the health care system, government benefit programs, other government regulatory programs and civil right laws.

e. **Abuse or Neglect:**
We may disclose your medical information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your medical information to the governmental entity authorized to receive such information if we believe that you have been a victim of abuse, neglect or domestic violence as is consistent with the requirements of applicable federal and state laws.

f. **Food and Drug Administration:**
We may disclose your medical information to a person or Patients Care Medical Supply required by the Food and Drug Administration to report adverse events, products defects or problems, biologic product deviations track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

g. **Legal Proceedings:**
We may disclose medical information it the course of any judicial or administrative proceeding, when required by a court order or administrative tribunal, and in
certain conditions in response to a subpoena, discovery request or other lawful process.

h. **Legal Proceedings:**
We may disclose medical information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include: (i) responding to a court order, subpoena, warrant, summons or otherwise required by law; (ii) identifying or locating a suspect, fugitive, material witness or missing person; (iii) pertaining to victims of a crime; (iv) suspecting that death has occurred as a result of criminal conduct; (v) in the event that a crime occurs on the premises of the practice; and (vi) responding to a medical emergent (not on the Practice's premises) and it is likely that a crime has occurred.
We may disclose medical information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to

i. **Coroners, Funeral Directors, and Organ Donors:**
perform other duties authorized by law. We may also disclose medical information to funeral directors as necessary to carry out their duties.

j. **Research:**
We may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when an Internal Review Board (“IRB”) or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to your privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate, written assurances that the PHI

will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

k. **Criminal Activity:**
Consistent with applicable federal and state laws, we may disclose your medical information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person of the public. We may also disclose medical information if it is necessary for law enforcement authorities to identify or apprehend an individual.

l. **Organ and Tissue Donation:**
If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

m. **Military Activity and National Security:**
If you are a member of the armed forces, we may use or disclose medical information, (i) as required by military command authorities; (ii) for the purpose of determining by the Department of Veteran Affairs of your eligibility for benefits; or (iii) for foreign military personnel to the appropriate foreign military authority. We may also disclose your medial information to authorized federal officials for conducting national security and intelligence activities, including for the protective services to the President or others legally authorized.

n. **Worker's Compensation:**
We may disclose your medical information as authorized to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illness.

o. **Inmates:**
We may use or disclose your medical information if you are an inmate or a correctional facility and our practice created or received your health information in the course of providing care to you.

p. **Required Uses and Disclosures:**
Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500, et seq. seq.

IV. The Following Is a Statement of Your Rights with Respect to Your Medical Information and a Brief Description of How You May Exercise These Rights.

a. **You have the right to inspect and copy your medical information.**
This means you may inspect and obtain a copy of medical information about you that has originated in our practice. We may charge you a reasonable fee for copying and mailing records. To the extent we maintain any portion of your PHI in electronic format, you have the right to receive such PHI from us in an electronic format. We will charge no more than actual labor cost to provide you electronic versions of your PHI that we maintain in electronic format.

After you have made a written request to our Privacy Contact at the following address: Patients Care Medical Supply, Inc - PO Box 246 Maurice, LA 70555, we will have thirty (30) days to satisfy your request. If we deny your request to inspect or copy your medical information, we will provide you with a written explanation of the denial. You may not have a right to inspect or copy psychotherapy notes. In some circumstances, you may have a right to have the decision to deny you access reviewed. Please contact the Privacy Contact if you have any questions about access to your medical record.

b. **You have the right to request a restriction of your medical information.**
You may ask us not to use or disclose part of your medical information for the purposes of treatment, payment or healthcare operations. You may also request that part of your medical information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice. You must state in writing the specific restriction requested and to whom you want the restriction to apply. You have the right to restrict information sent to your health plan or insurer for products or services that you paid for solely out-of-pocket and for which no claim was made to your health plan or insurer.

c. **We are not required to agree to your request.**
If we believe it is in your best interest to permit use and disclosure of your medical information, you medical information will not be restricted; provided, however, we must agree to your request to restrict disclosure of your medical information if: (i) the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law; and (ii) the information pertains solely to a health care item or service for which you (and not your health plan) have paid us in full. If we do agree to the requested restriction, we may not use or disclose your medical information in violation of that restriction unless it is needed to provide emergency treatment. Your written request must be specific as to what information you want to limit and to whom you want the limits to apply. The request should be sent, in writing, to our Privacy Contact.

d. **You have the right to request to receive confidential communications from us at a location other than your primary address.**
We will try to accommodate reasonable requests. Please make this request in writing to our Privacy Contact.

e. **You may have the right to have us amend your medical information.**
If you feel that medical information we have about you is incorrect or incomplete, you may request we amend the information. If you wish to request an amendment to your medical information, please contact our Privacy Contact, in writing to request our form Request to Amend Health Information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us.

f. **You have the right to receive an accounting of disclosures we have made, if any, of your medical information.**
This applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice. If excludes disclosures we may have made to you, family members or friends involved in your care, or for notification purposes. To receive information regarding disclosures made for a specific time period no longer than six (6) years and after April 14, 2003, please submit your request in writing to our Privacy Contact. We will notify you in writing of the cost involved in preparing this list. To the extent we maintain your PHI in electronic format, you may request an accounting of all electronic disclosures of your PHI for treatment, payment, or healthcare operations for the preceding three (3) years prior to such request.

g. **Uses and Disclosures of Protected Health Information Based Upon Your Written Authorization.**
Other uses and disclosures of your medical information not covered by this Notice or required by law will be made only with your written authorization. For example, most uses and disclosures of psychotherapy notes; PHI for marketing purposes; that constitute a sale of PHI and other than those described in this Notice, require authorization. You may revoke this authorization at any time, except to the extent that our practice has taken an action in reliance on the use or disclosure indicated in the prior authorization.

h. **Right to be Notified of a Breach.**
You have the right to be notified in the event that our practice (or a Business Associate or ours) discovers a breach of unsecured protected health information.

i. **Complaints:**
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Contact, in writing. We will not retaliate against you for filing a complaint.

Education Objectives

- ☐ Understands and can verbalize the prescription written by the physician.
- ☐ Understands, can verbalize and demonstrate the function and purpose of equipment.
- ☐ Understands and can demonstrate safe operation and preventative maintenance of the equipment.
- ☐ Understands and can verbalize how and when to order supplies, call for repairs and emergency procedures.
- ☐ I have been advised of certain equipment warranty and rent\purchase options available to me.
- ☐ Patient received Notice of Privacy Practices.

Safety Objectives

- ☐ Fire Extinguisher is present\recommended.
- ☐ Smoke Alarms are present\recommended and functional.
- ☐ Fire Escape plan has been developed.
- ☐ Electrical outlets, grounding is recommended.
- ☐ Smoking is prohibited in bed or around oxygen.
- ☐ Electrical appliances are kept away from water.
- ☐ Equipment and supplies are properly placed or stored.
- ☐ Patient received safety education material and rights and responsibilities.

Home Evaluation

- ☐ Home is suitable for the safe use of the ordered equipment.
- ☐ There is adequate access between rooms, maneuvering space, and surfaces for use of the mobility assistance device(s).

I have been given clear explanations and instructions by: M|DRIVER.FIRST_NAME M|DRIVER.LAST_NAME
Date: M|C|CURRENTDATE

I can contact Patients Care Medical Supply at any time, if I have questions about the services that I am receiving or concerns regarding billing practices

I have received the following Patient Instruction Sheet(s):

- ☐ Operation Safety Instructions For:
- ☐ Concentrator
- ☐ Aspirator
- ☐ Commode
- ☐ Operations Safety Instructions
- ☐ Cylinder Oxygen
- ☐ Nasal CPAP\BiPAP
- ☐ Ambulatory Aids
- ☐ Negative Pressure Wound Therapy
- ☐ Liquid Oxygen
- ☐ Hospital Beds
- ☐ Enteral Pump
- ☐ Apnea Monitor
- ☐ Handheld Nebulizer
- ☐ Wheel Chair
- ☐ Respiratory Equipment Cleaning Instructions

ACKNOWLEDGMENT OF RECEIPT - PATIENT ADMISSION PACKET

I, the undersigned, hereby acknowledge that I have received the Patients Care Medical Supply Patient Admission Packet (including but not limited to; the Medicare Supplier Standards, Patient Rights and Responsibilities, and Privacy Notice.) and instruction sheets via email and/or I know where to access them on the website at www.www.pcmsupply.com/documents.

I am aware that, should I have any questions or problems with my equipment, supplies, or concerns regarding billing practices, I can call Patients Care Medical Supply at the telephone number provided to me.

I am either the patient or a representative of the patient signing on behalf of the patient.

I consent to the release of my PHI as needed for the purposes of treatment, payment, legal requirements, and healthcare operation.

Signatures

	M|DRIVER.FIRST_NAME M|DRIVER.LAST_NAME	M|C|CURRENTDATE
Patient or Patient's Representative	**Company Representative**	**Date**

Relationship to Patient: (if not 'Self')

Reason Patient Could Not Sign: