**ASSIST HOME CARE, INC.**

**Patient Admission Packet**

Patient: M|SITE.SHIP_TO_NAME Patient ID: M|CUSTOMER.PATIENT_ID

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

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**AUTHORIZATIONS:** I hereby authorize and consent to the provision of products and/or services to me by ASSIST HOME CARE, INC. I understand that I am under the control of my physician and that ASSIST HOME CARE, INC is not liable for any act or omission when following the instructions of said physician. I authorize ASSIST HOME CARE, INC 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 ASSIST HOME CARE, INC, 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. ASSIST HOME CARE, INC 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 ASSIST HOME CARE, INC for authorized services/equipment furnished to me by ASSIST HOME CARE, INC. 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 ASSIST HOME CARE, INC 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. ASSIST HOME CARE, INC will submit your claim, but it remains your responsibility to make sure the claim is paid. We strongly recommend that you contact your insurance ASSIST HOME CARE, INC to discuss your plan provisions and coverage.** While insurance or other coverage may exist for the Equipment provided to me by ASSIST HOME CARE, INC, 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 ASSIST HOME CARE, INC denies or recoups payment for services/equipment originally thought to be covered.** I understand that if I fail to notify ASSIST HOME CARE, INC 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 ASSIST HOME CARE, INC, the rented equipment remains the property of ASSIST HOME CARE, INC, ownership will not be transferred until all amounts due ASSIST HOME CARE, INC are fully paid, and that the Equipment must remain within the service area unless written permission is given and documented by ASSIST HOME CARE, INC. I agree that if after reasonable notice I fail to pay any charge when due, ASSIST HOME CARE, INC 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, ASSIST HOME CARE, INC 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 ASSIST HOME CARE, INC 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/WARRANTY POLICY:** Returns are accepted only within **14 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. Returns are subject to a 20% re-stocking fee. ASSIST HOME CARE, INC honors the manufacturer's warranty for new equipment and parts. Equipment without a specified warranty will be warranted for 30 days against manufacturer defect, not if damaged due to negligence or misuse. Labor and travel time are not covered under the warranty.

**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 ASSIST HOME CARE, INC. I agree this agreement will be binding on my heirs, representatives and assignees. I certify that all patient information provided to ASSIST HOME CARE, INC 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.

**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.**

**Medicare DMEPOS Supplier Standards**

**Note: This is an abbreviated version of the supplier standards every Medicare DMEPOS supplier must meet in order to obtain and retain their billing privileges. These standards, in their entirety, are listed in 42 C.F.R. 424.57(c).**

1. A supplier must be in compliance with all applicable Federal and State licensure and regulatory requirements and cannot contract with an individual or entity to provide licensed services.
2. A supplier must provide complete and accurate information on the DMEPOS supplier application. Any changes to this information must be reported to the National Supplier Clearinghouse within 30 days.
3. An authorized individual (one whose signature is binding) must sign the application for billing privileges.
4. supplier must fill orders from its own inventory, or must contract with other companies for the purchase of items necessary to fill the order. A supplier may not contract with any entity that is currently excluded from the Medicare program, any State health care programs, or from any other Federal procurement or non-procurement programs.
5. A supplier must advise beneficiaries that they may rent or purchase inexpensive or routinely purchased durable medical equipment, and of the purchase option for capped rental equipment.
6. A supplier must notify beneficiaries of warranty coverage and honor all warranties under applicable State law, and repair or replace free of charge Medicare covered items that are under warranty.
7. A supplier must maintain a physical facility on an appropriate site. This standard requires that the location is accessible to the public and staffed during posted hours of business, with visible signage. The location must be at least 200 square feet and contain space for storing records.
8. A supplier must permit CMS, or its agents to conduct on-site inspections to ascertain the supplier's compliance with these standards.
9. A supplier must maintain a primary business telephone listed under the name of the business in a local directory or a toll free number available through directory assistance. The exclusive use of a beeper, answering machine, answering service or cell phone during posted business hours is prohibited.
10. A supplier must have comprehensive liability insurance in the amount of at least $300,000 that covers both the supplier's place of business and all customers and employees of the supplier. If the supplier manufactures its own items, this insurance must also cover product liability and completed operations.
11. A supplier must agree not to initiate telephone contact with beneficiaries, with a few exceptions allowed. This standard prohibits suppliers from contacting a Medicare beneficiary based on a physician's oral order unless an exception applies
12. A supplier is responsible for delivery and must instruct beneficiaries on use of Medicare covered items, and maintain proof of delivery.
13. A supplier must answer questions and respond to complaints of beneficiaries, and maintain documentation of such contacts.
14. A supplier must maintain and replace at no charge or repair directly, or through a service contract with another ASSIST HOME CARE, INC, Medicare-covered items it has rented to beneficiaries.
15. A supplier must accept returns of substandard (less than full quality for the particular item) or unsuitable items (inappropriate for the beneficiary at the time it was fitted and rented or sold) from beneficiaries.
16. A supplier must disclose these supplier standards to each beneficiary to whom it supplies a Medicare-covered item.
17. A supplier must disclose to the government any person having ownership, financial, or control interest in the supplier.
18. A supplier must not convey or reassign a supplier number; i.e., the supplier may not sell or allow another entity to use its Medicare billing number.

19. A supplier must have a complaint resolution protocol established to address beneficiary complaints that relate to these standards. A record of these complaints must be maintained at the physical facility.
20. Complaint records must include: the name, address, telephone number and health insurance claim number of the beneficiary, a summary of the complaint, and any actions taken to resolve it.
21. A supplier must agree to furnish CMS any information required by the Medicare statute and implementing regulations.
22. All suppliers must be accredited by a CMS-approved accreditation organization in order to receive and retain a supplier billing number. The accreditation must indicate the specific products and services, for which the supplier is accredited in order for the supplier to receive payment of those specific products and services (except for certain exempt pharmaceuticals). *Implementation Date - October 1, 2009*
23. All suppliers must notify their accreditation organization when a new DMEPOS location is opened.
24. All supplier locations, whether owned or subcontracted, must meet the DMEPOS quality standards and be separately accredited in order to bill Medicare.
25. All suppliers must disclose upon enrollment all products and services, including the addition of new product lines for which they are seeking accreditation.
26. Must meet the surety bond requirements specified in 42 C.F.R. 424.57(c). *Implementation date- May 4, 2009*
27. A supplier must obtain oxygen from a state-licensed oxygen supplier.
28. A supplier must maintain ordering and referring documentation consistent with provisions found in 42 C.F.R. 424.516(f).
29. DMEPOS suppliers are prohibited from sharing a practice location with certain other Medicare providers and suppliers.
30. DMEPOS suppliers must remain open to the public for a minimum of 30 hours per week with certain exceptions.

**Patient Rights & Responsibilities**

***As an individual receiving home care services, let it be known that you have the following rights:***

1. To select those who provide your home care services.
2. To be provided with legitimate identification by any person or persons who enter your residence to provide home care services for you.
3. To receive the appropriate or prescribed service in a professional manner without discrimination relative to your age, race, sex, religion, ethnic origin, sexual preference or physical/mental handicap.
4. To be dealt with and treated with friendliness, courtesy and respect by each and every individual representing the ASSIST HOME CARE, INC who provides treatment or services for you
5. To assist in the development and planning of your home care program so that it is designed to satisfy, as best as possible to your current needs.
6. To be provided with adequate information from which you can give your informed consent for the commencement of service, the continuation of service, the transfer of service to another home care provider, or the termination of service.
7. To express concerns or grievances or recommend modifications to your home care services without fear of discrimination or reprisal. The Medicare hotline number is 1-866-238-9650.
8. To request and receive complete and up-to-date information relative to your condition, treatment, alternative treatments and risks of treatment.
9. To receive treatment and services within the scope of your home care plan, promptly and professionally, while being fully informed as to ASSIST HOME CARE, INC policies, procedures and charges.
10. To refuse treatment and services within the boundaries set by law, and to receive professional information relative to the ramifications or consequences that will or may result due to such refusal.
11. To request and receive the opportunity to examine or review your medical records.

***As an individual receiving home care services, let it be known that you have the following responsibilities:***

1. To provide accurate and complete information and notify ASSIST HOME CARE, INC of any changes in status, including medical, change of address or insurance.
2. To advise ASSIST HOME CARE, INC of any changes in phone number, address, physician, insurance or payor source.
3. To comply with Physician's prescribed treatment and be responsible for the outcomes if they do not follow the prescribed treatment.
4. To make known whether you understand the products and services provided and what you are expected to do.
5. To comply with the service plan and to communicate any change in the physician's order.
6. To plan to any emergencies that may occur in the home.
7. To respect the rights, professional integrity and dignity of those providing your care.
8. To notify our staff if you wish to cancel services or change a scheduled visit.
9. To follow any instructions, rules and regulations as provided by ASSIST HOME CARE, INC.
10. To properly store, clean and maintain your equipment as recommended by the manufacturer.
11. To contact ASSIST HOME CARE, INC when equipment is not working properly and to allow ASSIST HOME CARE, INC staff access to equipment for repair and maintenance.
12. To meet the financial obligations agreed to with ASSIST HOME CARE, INC.

**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 Lifts
- Trapeze bars

Oxygen equipment is rented for 36 months, at which time the equipment is considered capped but remains the property of ASSIST HOME CARE, INC. We will maintain it for the next 24 months. After 60 months, ASSIST HOME CARE, INC 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 your 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 company 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:
*, 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:**
If you are unhappy with the services provided by this company, please call 1-866-644-9840. We will respond withing 5 calendar days. In the event your complaint is not resolved to your satisfaction you can contact our accrediting organization, The Compliance Team, at www.thecomplianceteam.org or by calling 1-888-291-5353.

**Acknowledgment of Receipt of Patient Booklet**

I, the undersigned, hereby acknowledge that I have received the ASSIST HOME CARE, INC Patient Booklet. I am either the patient or a representative of the patient signing on behalf of the patient. The ASSIST HOME CARE, INC Representative has explained the section of the Booklet, and I have had the opportunity to ask questions, and have my questions answered. The following sections of the Booklet were discussed:

- ***Quality Service Goals***
- ***Rights & Responsibilities***
- ***Medicare Supplier Standards 30 (link)***
- ***AOB Signature***
- ***Emergency Preparedness***
- ***Infection Control Tips/Equipment Instructions***
- ***Service Availability (Scope of Products)***
- ***Delivery and Service***
- ***Billing and Payment***
- ***Customer Survey***
- ***Warranty Information***
- ***Patient Communication***
- ***Notice of Privacy Practices - HIPAA***
- ***Cleaning & Equipment Maintenance***

I am aware that, should I have any questions or problems with my equipment or supplies, I can call ASSIST HOME CARE, INC at the telephone number provided to me.

The ASSIST HOME CARE, INC Representative has done an assessment of my home and has identified items or areas that need to be changed to improve the safety of my environment. I have made note of these items or areas, and assume responsibility for making the suggested changes, or the responsibility for not making the changes.

**Education Objectives**

- ☐ Understands and can verbalize the prescription written by the physician.
- ☐ Understands, can verbalize and demonstrate the function and purpose of equipment/supplies.
- ☐ Equipment was check and in good working order (Confirmed supplies have not expired)

- [ ] Patient/Caregive was given a copy of this form.
- [ ] 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).
- ○ Follow-up visit recommended ○ Follow-up by phone & As needed

I have been given clear explanations and instructions by: M|DRIVER.FIRST_NAME M|DRIVER.LAST_NAME Date: M|C|CURRENTDATE
I can contact ASSIST HOME CARE, INC 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 | [ ] WheelChair | [ ] Respiratory Equipment Cleaning Instructions | |

**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:**