## Assist Home Care, Inc.

## Customer Agreement Statement

Patient Name: M|SITE.SHIP_TO_NAME DoB: M|CUSTOMER.DATE_OF_BIRTH Patient ID#: M|CUSTOMER.PATIENT_ID

**ASSIGNMENT OF BENEFITS:** I confirm that the information provided by me in applying for payment under Title XVIII (Medicare) of the Social Security Act and any other insurance is true and correct. I request payments under my medical insurance program be made to Assist Home Care, Inc. on any unpaid bills for services furnished to me by Assist Home Care, Inc.. A photocopy of this Assignment shall be considered as effective and valid as the original.

**RELEASE OF INFORMATION:** I authorize any holder of medical or other related information about me be released to Assist Home Care, Inc. and its agents for the purpose of determining benefits for related services and applying for payment. I authorize Assist Home Care, Inc. to release to CMS, its intermediaries, or commercial insurance companies and accrediting body's information needed for insurance claims in quality assessment purposes.
I received instructions and understands that Medicare defines the equipment that I received as being either a capped rental or an inexpensive or routinely purchased item(s).

**Accepted Capped Rental Items**

- 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 (except oxygen equipment, which caps out at 36 months and ownership does not transfer).
- 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.
- Examples of this type of equipment include: hospital beds, wheelchairs, alternating pressure pads, air-fluidized beds, nebulizers, suction pumps, continuous airway pressure (CPAP) devices, patient lifts, and trapeze bars.

**Accepted Routinely Purchase 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.
- Examples of this type of equipment include: canes, walkers, crutches, commode chairs, low pressure and positioning equalization pads, seat lift mechanisms and etc.
- I select the: ○ Purchase Option ○ Rental Option for the requested "routinely purchased" items.

**WARRANTY DECLARATION**
We at Assist Home Care, Inc. neither offer, nor convey, nor imply in writing any warranty other than the warranty supplied by the manufacturers of the product(s).

I have been instructed and understand the warranty coverage of the product I have received.

I\we have received and understand the proper use & safety\instruction booklet for the equipment and\or supplies received. I understand the risks and complications of the equipment prescribed by my physician. I understand that any questions\problems should be called to Assist Home Care, Inc. as soon as possible.

I hereby consent to such treatment as prescribed by my physician. I understand that only care that is appropriate to the home setting will be provided and that Assist Home Care, Inc. will exercise good faith in this relationship. This consent is intended as a waiver of liability for treatment excepting acts of neglect. I also understand that, due to Federal and State Pharmacy regulations, drugs, and ancillary items prescribed for home therapy cannot be re-dispensed. Only durable medical equipment may be returned to be re-dispensed to another patient in the future. Further, if "used", I understand and accept that the equipment is used or refurbished.

The following individuals have my permission to discuss my account details with employees of Assist Home Care, Inc.. If no one is listed, Assist Home Care, Inc. employees may only discuss my account with me:

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|---|---|---|---|---|---|---|---|
| Name: | | Phone: | | Relationship: | Select | DoB: | |
| Name: | | Phone: | | Relationship: | Select | DoB: | |

**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:** | | |