



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_NUMB

M|SITE.SHIP_TO_CITY, M|SITE.SHIP_TO_STATE

ER

M|SITE.SHIP_TO_ZIP

AUTHORIZATIONS: I hereby authorize and consent to the provision of products and/or services to me by Midsouth Medical, Inc. I understand that I am under the control of my physician and that Midsouth Medical, Inc. is not liable for any act or omission when following the instructions of said physician. I authorize Midsouth Medical, Inc. to contact me via mail, email, phone, or text 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 Midsouth Medical, 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. Midsouth Medical, 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 Midsouth Medical, Inc. for authorized services/equipment furnished to me by Midsouth Medical, 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 Midsouth Medical, 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. Midsouth Medical, 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 company to discuss your plan provisions and coverage. It is important to know that some insurance companies do not pay the exact amount for services that are billed. We attempt to provide you with the most accurate estimate of the charges that you are responsible for prior to services being rendered but please be aware that after the insurance processes your claim your patient responsibility portion may be different from the estimate provided. **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, Midsouth Medical, Inc. requires payment of the estimate provided. A form of payment on file will be required to satisfy any balances that are not paid by your insurance, the patient portion of rental charges incurred in future months.** I understand that if I fail to notify Midsouth Medical, 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 Midsouth Medical, Inc., the rented equipment remains the property of Midsouth Medical, Inc., ownership will not be transferred until all amounts due Midsouth Medical, Inc. are fully paid, and that the equipment must remain within the service area unless written permission is given and documented by Midsouth Medical, Inc. I agree that if after reasonable notice I fail to pay any charge when due, Midsouth Medical, 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. **If you enter a hospital, nursing home or hospice care, or no longer medically need the rented equipment, you must notify Midsouth Medical, 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 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. Equipment that is rented will be returned after the practitioner has discontinued service. Midsouth Medical, Inc. 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 manufacture, Midsouth Medical, Inc. will uphold the manufacturer's warranty coverage and we will honor all warranties under applicable law. Midsouth Medical, Inc. 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 for all 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 Midsouth Medical, Inc. I agree this agreement will be binding on my heirs, representatives, and assignees. I certify that all patient information provided to Midsouth Medical, 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.

GRIEVANCE/COMPLAINT REPORTING: You may complain to us or to the Secretary of Health and Human Services (200 Independence Ave. S.W., Washington D.0 20201) if you believe your privacy rights have been violated by us. We will not retaliate against you for filing a complaint. Please call 318-855-0411 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: 3209 Breard Street Monroe, LA. 71291. You can expect a written response within fourteen working days or receipt.

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.

PATIENT BILL OF RIGHTS AND RESPONSIBILITIES

We believe that all patients receiving services from Midsouth Medical, Inc. 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 Midsouth Medical, Inc. any malfunctions or defects in rental equipment so that repair/ replacement can be arranged.
3. Patient agrees to provide Midsouth Medical, Inc. 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 Midsouth Medical, Inc.
6. Patient agrees to notify Midsouth Medical, Inc. 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 Midsouth Medical, Inc. for any services furnished by Midsouth Medical, Inc.
8. Patient agrees to accept all monetary responsibility for home medical equipment furnished by Midsouth Medical, Inc.
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 Midsouth Medical, Inc.
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 Midsouth Medical, Inc. always unless equipment is purchased and paid for in full.
13. Patient agrees that Midsouth Medical, Inc. 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 Midsouth Medical, Inc. 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.

All staff members will understand and be able to discuss the Patient Bill of Rights and Responsibilities with the patient and caregiver(s). Each staff member will receive training during orientation and attend an annual in-service education class on the Patient Bill of Rights and Responsibilities.

Medicare DMEPOS Supplier Standards

The products and/or services provided to you by (Midsouth Medical, Inc.) 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	Air-fluidized Beds
Tilt in Space & Pediatric Manual Wheelchairs	Nebulizers
Standard & Power Wheelchairs	Suctions Pumps
Standard & Power Wheelchair accessories/replacement parts	Continuous Airway Pressure (CPAP/BIPAP) Devices
Hospital Beds	Patient Lifts
Alternating Pressure Pads	Trapeze bars

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

CPM Machines Medicare will pay a daily rental fee for a period not to exceed 21 days from surgery.

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):

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| Canes | Blood Glucose Monitors |
| Walkers | Seat Lift Mechanisms |
| Crutches | Pneumatic Compressors (Lymphedema-Pumps) |
| Commodes | Bed Side Rails |
| Low Pressure and Position Equalizing Pads | |

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

- Purchase Option
 Rental Option

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
The Midsouth Medical, Inc. Representative has done an assessment of my home. If there were 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.

ACKNOWLEDGMENT OF RECEIPT - PATIENT ADMISSION PACKET

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

I am aware that, should I have any questions or problems with my equipment, supplies, or concerns regarding billing practices, I can call Midsouth Medical, Inc. 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: _____