

InHealth Technologies a division of Helix Medical LLC
CLIENT/PATIENT SERVICE AGREEMENT

Client/Patient Name: _____ ID _____

Authorization/Consent for Care/Service: I have been informed of the home care options available to me and of the selection of providers from which I may choose. I authorize InHealth Technologies a division of Helix Medical LLC under the direction of the prescribing physician, to provide home medical equipment, supplies and services as prescribed by my physician. I understand and have been properly trained by my doctor or Speech Language Pathologist on using the products prescribed to me.

Assignment of Benefits/Authorization for Payment: I hereby assign all benefits and payments to be made directly InHealth Technologies a division of Helix Medical LLC, Inc for any home medical equipment, supplies and services furnished to me in conjunction with my home care. I authorize InHealth Technologies a division of Helix Medical LLC to seek such benefits and payments on my behalf. It is understood that, as a courtesy, InHealth Technologies a division of Helix Medical LLC will bill Medicare/Medicaid or other federally funded sources and other payers and insurer(s) providing coverage, with a copy to InHealth Technologies a division of Helix Medical LLC I understand that I am responsible for providing all necessary information and for making sure all certification and enrollment requirements are fulfilled. Any changes in the policy must be reported to InHealth Technologies a division of Helix Medical LLC within 30 days of the event. I have been informed by InHealth Technologies a division of Helix Medical LLC of the medical necessity for the services prescribed by my physician. I understand that in the event services are deemed not reasonable and necessary, payment may be denied and that I will be fully responsible for payment.

Release of Information: I hereby request and authorize InHealth Technologies a division of Helix Medical LLC, the prescribing physician, hospital, and any other holder of information relevant to service, to release information upon request, to InHealth Technologies a division of Helix Medical LLC, any payer source, physician, or any other medical personnel or agency involved with service. I also authorize InHealth Technologies a division of Helix Medical LLC to review medical history and payer information for the purpose of providing home health care.

Financial Responsibility: I understand and agree that I am responsible for the payment of any and all sums that may become due for the services provided. These sums include, but are not limited to, all deductibles, co-payments, out-of-pocket requirements, and non-covered services. If for any reason and to any extent, InHealth Technologies a division of Helix Medical LLC does not receive payment from my payer source, I hereby agree to pay InHealth Technologies a division of Helix Medical LLC for the balance in full, within 30 days of receipt of invoice. All charges not paid within 45 days of billing date shall be assessed late charges. I am liable for all charges, including collection costs and all attorneys cost. I am responsible for all charges regardless of my payer unless my agreement with my health plan holds me harmless.

Returned Goods: I understand that, due to Federal and State Pharmacy Regulations ancillary items prescribed for home health care cannot be re-dispensed. Therefore, ancillary items cannot be returned for credit. Home Medical Equipment that is rented will be returned after the physician has discontinued service. Sale items cannot be returned. InHealth Technologies a division of Helix Medical LLC 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.

Client/Patient Handouts: I acknowledge that I have received a copy of the Client/patient Handouts which contains Client/patient Rights and Responsibilities, Supplier Standards, Home Safety Information, HIPPA Privacy Standards, Emergency Planning, and Advance Directive Information. I acknowledge that the information in the Client/patient Handouts has been explained to me and that I understand the information. I understand my right to formulate and to issue Advance Directives to be followed should I become incapacitated. I will furnish InHealth Technologies a division of Helix Medical LLC with a copy of such document.

Grievance Reporting: I acknowledge that I have been informed of the procedure to report a grievance should I become dissatisfied with any portion of my home care experience. I understand that I may lodge a complaint without concern for reprisal, discrimination, or unreasonable interruption of service. To place a grievance, please call 800-477-5969 and speak to the Customer Services Supervisor. If your complaint is not resolved to your satisfaction within 5 working days, you may initiate a formal grievance, in writing and forward it to the Governing Body. You can expect a written response within 7 working days or receipt.

Home Health Hotline: You may also make inquiries or complaints about this company by calling your local Social Services Department and/or ACHC.

Change of Insurance: I understand I must notify InHealth Technologies by phone, United States mail, or e-mail immediately if Medicare becomes my primary insurance payer or I begin receiving any Home Health services AFTER returning these forms. If InHealth Technologies is not notified immediately upon enrollment, they will not be responsible for refunding any unpaid Medicare claims to me.

Client/patient: _____ Date: _____

Witness: _____ Date: _____