INHEALTH TECHNOLOGIES®

CLIENT/PATIENT INFORMATION SHEET

Blom-Singer® voice restoration systems

1110 Mark Avenue • Carpinteria, CA 93013
Tel: (800) 477-5969 • (805) 684-9337
medicare@inhealth.com • www.inhealth.com

IMPORTANT: THIS FORM MUST BE FILLED OUT, SIGNED AND RETURNED FOR CONTINUED SERVICE

SECTION A: Patient Information

Name: _____ Gender: ○ M ◉ F

Address: _____

City: _____ State: _____ Zip: _____

Telephone: ( ) _____ E-mail: _____

Date of Birth: / / _____ Social Security Number: — — _____

Diagnosis for Service Provided: _____

Is Client/Patient in a Hospital, Home Care or Care Facility? ○ Y ◉ N If Yes, Start Date: / /

Emergency Contact: _____ Telephone: ( ) _____

Caregiver (if applicable): _____ Telephone: ( ) _____

SECTION B: Physician Information

Ordering / Prescribing Physician Name: _____

Physician NPI Number: _____

Telephone: ( ) _____ FAX: ( ) _____

SECTION C: Primary Insurance Information

PLEASE SUBMIT A COPY OF ALL INSURANCE CARDS, FRONT AND BACK. This form needs to be submitted only one time, unless information has changed. For secondary insurance, please complete the form on the reverse side.

If Medicare is your primary insurer for medical (Part B) claims, please provide your Medicare Claim Number.

☐ **I would like to enroll in Medicare Assignment***

Medicare Claim Number: _____

Insurance Company/Plan Name: _____ Telephone: ( ) _____

Policy/Member ID Number: _____ Group Number: _____

Name of Insured (if not self): _____ Date of Birth: / / _____

Relation to Insured: ○ Self ○ Spouse ○ Child ◉ Other Condition Related to: ○ Employment ◉ Accident

*For more information about Medicare Assignment, please visit http://www.inhealth.com/category_s/286.htm

SECTION D: Secondary Insurance Information

The secondary payer information must be completely filled out for us to include this information along with your Medicare claims. Any incomplete forms will delay processing. **Please include a copy of your insurance card, front and back.**

If Medicare is your secondary insurer for medical (Part B) claims, please provide your Medicare Claim Number. You must file your claims to the appropriate primary insurer (i.e., employer group plan, worker's comp, etc.).

Medicare Claim Number: _____

If you have other insurance or a Medicare replacement/supplement plan as your secondary, please indicate below.

Insurance Company/Plan Name: _____ **Telephone: ( )** _____

Policy/Member ID Number: _____ **Group Number:** _____

Name of Insured (if not self): _____ **Date of Birth: / /** _____

Relation to Insured: ◯ Self ◯ Spouse ◯ Child ◉ Other **Condition Related to:** ◉ Employment ◯ Accident

Section E: Patient Payment Responsibilities / Patient Signature Required

I understand that I am responsible for payment, regardless of benefits quoted to me by InHealth Technologies or Medicare, neither of which are a guarantee of coverage/reimbursement. I also understand that Medicare coverage/reimbursement for products I buy, if any, is decided by Medicare on an individual claim-by-claim basis and that previous Medicare coverage/reimbursement is not a guarantee of future coverage/reimbursement. I also understand that once InHealth Technologies files a claim with Medicare on my behalf, I may not return the products to InHealth Technologies for a refund.

I also understand that I am required to prepay for the Blom-Singer® Voice Prostheses, ATSV II and HumidiFilter Systems and accessories, Blom-Singer Laryngectomy Tubes, Servox® products and accessories, Barton-Mayo™ Tracheostoma Button, and all InHealth Technologies accessory supplies. However, I understand that InHealth Technologies will submit to Medicare a claim for reimbursement (to me) of those costs. I agree that InHealth Technologies will do so as a courtesy to me and that InHealth Technologies is not responsible for an unfavorable reimbursement decision on such a claim by Medicare.

Section F: Authorization to Release Patient Health Information to Insurance / Patient Signature Required

I authorize InHealth Technologies to release to Medicare all medical and personal information about me that may be necessary to determine benefits and obtain payment, as set forth in InHealth Technologies Notice of Privacy Practices previously provided to me.

Section G: Product Use

I agree to use all InHealth Technologies Products only as prescribed by my practitioner and in accordance with the manufacturer's instructions.

CLIENT/PATIENT SERVICE AGREEMENT/PLAN OF SERVICE

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 Freudenberg 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 authorize InHealth Technologies, a Division of Freudenberg Medical, LLC, to seek benefits and payments on my behalf. It is understood that, as a courtesy InHealth Technologies, a Division of Freudenberg Medical, LLC, will bill Medicare. 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 Freudenberg Medical, LLC, within 30 days of the event. I have been informed by InHealth Technologies, a Division of Freudenberg 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 Freudenberg 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 Freudenberg Medical, LLC, any payer source, physician, or any other medical personnel or agency involved with service. I also authorize InHealth Technologies, a Division of Freudenberg 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 Freudenberg Medical, LLC, does not receive payment from my payer source, I hereby agree to pay InHealth Technologies, a Division of Freudenberg 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 attorney costs. 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 Freudenberg 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, HIPAA 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 Freudenberg 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 14 working days or receipt. Office of Inspector General Department of Health and Human Services: 1-800-HHS-TIPS (1-800-447-8477). To reach our accrediting body, please call Accreditation Commission for Health Care (ACHC): 919-785-1214.

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 my insurance coverage changes in any way 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.

Plan of Service: Identified needs/problems: The patient may be unfamiliar with use of the product(s) provided. Expected outcomes: The patient will be provided the product(s) to comply with the physician's prescription. The patient will use the product(s) as prescribed by the physician. The patient will know how to obtain follow-up services as needed. The patient will use products in accordance with instructions for use.

All client/patients receiving services from InHealth Technologies should be informed of their rights, available at:
http://www.inhealth.com/v/vspfiles/pdf/forms/170618.00_Client_Patient_Bill_of_Rights.pdf

☐ Please check here to confirm you have reviewed the Patient Bill of Rights.

Sign below:

Client / Patient Signature: _____ Date: _____

Witness: _____ Date: _____

Please return this form upon completion.

Mail: InHealth Technologies • 1110 Mark Avenue • Carpinteria, CA 93013
Email: medicare@inhealth.com
Fax: 888.371.1530

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