Customer Welcome Guide

Monday – Friday

8:30 am to 4:00 pm

Closed from 12:00 pm to 1:00 pm for Lunch

VISIT OUR WEBSITE:

www.orthomotiontech.com

WELCOME

Thank you for choosing the Company (OrthoMotion/Family Home Medical), as your provider for home medical equipment and supplies. We appreciate your business and any chance to service you. Our main goal is to provide a friendly, caring staff to assist in your home medical equipment needs.

SERVICES OFFERED

We currently provide the following equipment:

- Speech Generating Devices
- CPAP Machines
- BiPAP Machines
- BiPAP ASV
- BiPAP S/T
- Motorized Wheelchairs
- Motorized Scooters
- Nebulizer Machines
- Nebulizer Supplies
- PAP Supplies

MEDICAL RECORDS

The Company does a very thorough job of collecting medical records from multiple sources in order to get your equipment approved. Thus, a lot of work and man hours goes into gathering these records. As a result, if you would like a copy of these records, they are readily available to send to you by mail or fax for a charge of $30.00. You may contact our office to get these records at (601)898-3774.

BUSINESS LOCATIONS & PHONE NUMBERS

Please contact the location nearest you:

Ortho in Clifton
505 S. Main St.
Clifton, IL 60927
Phone: (815)694-2619
Fax: (815)694-2022

Family Home Medical in Watseka, IL
200 North Laird Lane
Watseka, IL 60970
Phone: (815)432-6155
Fax: (815)432-6299

Family Home Medical
163 E Bethel Drive,
Bourbonnais IL 60914
Phone: 800-722-7313

MISSION STATEMENT

The Company's mission is to meet home medical equipment needs of our clients/patients in our service area by providing the highest quality medical equipment supplies and services. We respect the rights of our clients/patients, and dedicated to providing responsive, timely customer service. We ensure that members of our team received ongoing continuing education so that they are knowledgeable about home health care technology and can serve our clients/patients effectively.

MANUFACTURER'S LIMITED WARRANTY

The Company honors the manufacturer's warranty for new equipment and parts. All new purchase equipment comes with the manufacturer's warranty. The Company will exchange or repair defective or damaged equipment within the manufacturer's guidelines.

Rental equipment also comes with a warranty. For rental equipment, all warranties are effective from the first day of rental. If the manufacturer's warranty is no longer in effect, The Company offers repair or replacement service for the equipment as long as it is in a rental state, without a service charge. If the equipment converts from rental to purchase, the Company will repair the equipment at an hourly rate plus the cost of parts, in accordance with insurance company guidelines. The Company only provides service and/or repairs to wheelchairs that were provided by the Company. Warranties do not cover equipment that was modified by the client, or when damaged due to negligence or abuse while not operating or caring for the equipment in a manner consistent with the use or care for which it was designed. Misuse of the equipment includes patient use of equipment outside of the manufacturer specifications of height and or weight limits. Misuse also includes using the equipment outside of the home.

Labor and travel time are not covered under the warranty.

ABUSE OF EQUIPMENT

Your equipment has been issued to you and is your responsibility to take care of. Please note that all manufacturer warranties do not cover items that have become damaged or failed because of abuse or neglect. Your insurance company will also not cover the item if it needs replacing prior to its useful lifetime. Thus, if any equipment fails because of abuse or neglect, you are responsible for the service call, any and all labor, and any and all parts re- quired to make the equipment functional again. Thus, it is very important that you take care of your equipment and treat it kindly to avoid any other charges.

RETURN POLICY

Private Purchase items may be returned within 5 days with the original receipt and in original unused condition Special order items have a 25% restocking fee. Disposable supplies cannot be accepted for return or credit, except for defective supplies which may be exchanged only. Insurance billable "purchase" items may only be returned in their original unused condition within 5 days of sale date. Original delivery tickets are required. Insurance will be billed for 1 rental cycle on any returned "purchase" medical equipment.

***Disposable supplies cannot be accepted for return or credit, except for defective supplies which may be exchanged only*

Oxygen and CPAP equipment (insurance billable "rental" medical equipment) may ONLY be returned with a written MD prescription to discontinue use of said equipment or by signing an AMA (Against Medical Advice). It is the patient's responsibility to let us know monthly if these items are being used. If the items are not being used, you can call and request pickup and state the reason why the equipment is no longer needed. At the time of pick up, you will be required to sign a pick-up ticket and a discharge summary stating the reason for pick up. If you disagree with the reasoning, you will need to notify the technician immediately and not sign the delivery paperwork.

BASIC HOME SAFETY

Equipment Operation

- Follow the provided instructions for operating the equipment.
- Never reset, bypass, or cover alarms, and be sure alarms are not covered up when the device is carried in a bag.

Fire safety

- Install smoke detectors in the home. Test them monthly and change the batteries twice a year.
- Identify doors, windows, or alternative exits that may be used in a fire.
- Post the fire department's phone number by each phone.
- Purchase a fire extinguisher and ensure that family members know how to use it.

Electric

- Use approved surge protectors rather than extension cords when possible.
- Do not stretch electrical cords across walkways where they may present a tripping hazard.
- Arrange furniture so that outlets may be used without an extension cord.
- Do not set furniture on top of electrical cords. The cord could become damaged and create potential fire and shock hazards.
- Do not run electrical cords under carpeting as it may cause a fire.
- Do not overload outlets.
- Use a light bulb of the correct type and wattage to avoid overheating and potential fire hazards.
- Keep heaters away from passageways and flammable items (e.g., curtains).

Lighting

- Make sure stairways are clearly lit from top to bottom so that each step is visible.
- Install light switches at the top and bottom of the stairs.
- Keep a flashlight close at hand.
- Motion sensors that activate lighting in outdoor environments may offer safety and security.

Floors

- Remove loose carpeting or throw rugs that slide.
- Secure rugs and runners by attaching double-faced carpet tape or rubber matting to the underside.
- Be sure that handrails run from the top to the bottom of a flight of stairs.
- Make sure there are no bulges in floor coverings.
- Telephones
- A telephone with lighted keypads and large numbers may be recommended.
- Place a phone where it would be accessible in case of an accident where the client/patient is unable to stand.
- Post emergency numbers and the residence address near each phone.

Kitchens

- Do not store non-cooking equipment (e.g., towels, plastic utensils} near the stovetop as it may present a fire or burn hazard.
- Do not let loose-fitting clothing drape over burners when cooking.
- Use rear burners when possible.
- Turn handles on pots and pans in towards the back wall to avoid accidents.

Bathrooms

- Install a nightlight in the bathroom.
- Apply non-slip strips on shower and bathtub floors.
- Avoid water temperatures higher than 120 degrees to avoid scalding
- Install grab bars to help patients/clients get in and out of the tub and shower

EMERGENCY PREPAREDNESS

It is important to prepare for possible disasters and other emergencies. The following information is provided to you as a guide to help you be prepared should a natural or human-caused disaster strike your area.

The following items should be kept in an easy-to-carry kit that you can use at home or take with you should you be forced to evacuate your home:

- Water - one gallon per person, per day (3-day supply for evacuation, 2-week supply for home)
- Food - non-perishable, easy-to-prepare items (3-day supply for evacuation, 2-week supply for home)
- Flashlight
- Battery-powered or hand-crank radio (NOAA Weather Radio is suggested)
- Extra batteries
- First aid kit
- Medications (7-day supply) and medical items
- Multi-purpose tool
- Sanitation and personal hygiene items
- Copies of personal documents
    - Medication list and pertinent medical information
    - Proof of address
    - Deed/lease to home
    - Passports, birth certificates, insurance policies
- Cell phone with chargers
- Family and emergency contact info
- Extra cash
- Emergency blanket
- Map(s) of the area
- Additional items may be needed to accommodate your family's needs

Make a plan with your family or household members

- Plan what to do in case you are separated during an emergency
- Plan what to do if you have to evacuate

Be informed

- Be aware of how local authorities will notify you during a disaster
- Make sure that at least one member of your household is trained in First Aid and CPR
- The American Red Cross is an excellent resource to help you be prepared for emergencies. Their website address is: www.RedCross.org

PATIENT/CLIENT CARE

The Company has policies and procedures in place to ensure that customer service and the care of our patients are not interrupted in the event of an emergency or disaster. All employees are educated about the process to meet client/patient needs in a disaster or crisis situation.

GENERAL BILLING INFORMATION

Insurance is billed as a courtesy to our patients. All balances are your responsibility whether your insurance company pays or not. Your insurance policy is a contract between you and your insurance company; we are not a party to that contract. Please be aware that some, and perhaps all, of the services provided may be non-covered and not considered reasonable and necessary under the Medicare Program and/or other medical insurance. All copays and deductibles are due upon invoice receipt and a valid credit card will be collected at the time services are rendered.

The cost of medical equipment provided by the Company is ultimately the customer's responsibility. However, as a courtesy to you, we will file claims with your insurance. If you have a change in insurance carrier, please notify our billing department immediately. If we receive a denial due to a change in insurance, we will bill the patient directly.

It is the patient's responsibility to know his or her health insurance benefits. Patients will be charged for any deductible or co-pay that their health plan does not cover.

Medical billing is confusing because there is a list price that we would charge if you did not have insurance and a contract price that varies depending on if you have Medicare, TennCare, or private insurance.

Very rarely does insurance pay 100% of the cost of medical treatment. Most insurance plans have an annual deductible that is an out-of-pocket expense to you, and they usually pay 80%-90% of the contracted price after the deductible has been met. Even Medicare has a $226.00 annual deductible that must be met, and then pays 80% of the contracted price.

To bill for most types of equipment, your physician will need to sign off on an order. It frequently takes 30 days or longer to get this form back from the physician before we can bill your insurance. Our normal billing procedure is to bill your primary insurance first. Once they process the claim, we will bill your secondary insurance, if you have one. This procedure can take several months.

If you have any questions about our billing, please call and ask to speak to someone in our Billing Department. The Company's main line is (601)898-3774

Medicare, along with most insurance companies, rent certain pieces of equipment yet usually purchase other pieces equipment. You will find the most common below:

Rental (Medicare)	Purchase (Routinely)
Power Wheelchairs (13 months)	**Speech Generating Devices**
Nebulizers (13 months)	**PAP Supplies**
CPAP (13 months)	
BIPAP (13 months)	
Motorized Scooters (13 months)	

Below are some items that are generally not covered by insurance companies:

Over Bed Tables	Gloves
Bathroom Aids (adults)	Water for Humidifiers
Reacher/Hip Kit	Replacement Bluetooth Speaker for SGD
Transfer Boards	Replacement SGD Carrying Bag and Straps

MEDICARE COVERAGE AND BILLING FOR SERVICE AND REPAIRS

If Medicare originally paid for your unit and your Medicare coverage has not changed, Medicare may cover the cost of service and repairs to your unit. Repairs to purchased equipment are covered when necessary for the correct operation of the unit. Extensive maintenance as recommended by the manufacturer and performed by authorized technicians is covered.

The Company provides Medicare covered services and repairs to units originally purchased from us. We bill Medicare directly for the charges. If your claim is approved, Medicare pays us directly; however, you may owe a deductible and/or co-payment. All claims may be subject to review and appeal.

RENTAL PERIOD WHILE INPATIENT

If you are admitted to a hospital, nursing home, in-patient rehab center, skilled nursing care or hospice, Medicare may not provide service and repairs to your unit; you will be responsible for your durable medical equipment expenses. This coverage does NOT apply to cosmetic items, accessories, trim, malicious abuse, or intentional neglect. This coverage does not cover a technician trip charge to come to your home outside of our normal coverage territory. For that reason, you may bring your equipment to one of our locations to avoid this charge. Parts not covered by warranty will be billed to Medicare.

If the equipment provided to you is under rental contract, it is your responsibility to contact our office if you are admitted to the hospital or skilled nursing facility for any length of time, including just one night. Your insurance will NOT cover the equipment provided to you if you are in a hospital or skilled nursing facility. If you let us know, we will work on re-adjusting the claim so it can be covered. If you do not let us know, your claim will be denied, and you will be responsible for payment! Please contact our office at (601)898-3774 to inform us of any inpatient stays.

MEDICARE CLAIMS QUESTIONS

The Company is not an agent of Medicare, and we are not physicians. We cannot guarantee that your claim will be accepted or paid. We have provided you with an estimate of your benefits coverage based upon the information given us. This is not a guarantee of payment by Medicare or other Insurance Carriers, and you may owe more or less than the estimated amount. If you have ANY questions about Medicare or the claims process, PLEASE refer to the CMS Medicare Supplier Standards included in this document for your Medicare contact phone number.

My signature in the Delivery Paperwork section of the Customer Signature Page certifies that I have read, and I understand the following rights:

1. I may revoke either or both authorizations at any time by notifying the Company, ATTN: Privacy Officer, 1100 Hatcher Lane, Columbia TN 38401. I understand that my revocation will not affect any action the Company took before it received my recovation, including the use of printed materials, including pertinent medical documentation once the informaiton has been sent to my government officials.
2. I may see and receive another copy of this autorization form if I ask for it.
3. I am not required to sign this form in order to be eligible for treatment or other services or benefits for the Company's products.
4. I have been made aware of the Company's "Notice of Privacy Practices".
5. The name, photograph, testimonial and/or other materials used or disclosed under these authorizatinos may be re-disclosed by the recipient and may no longer be protected by federal privacy laws after re-disclosure.

INEXPENSIVE OR ROUTINELY PURCHASED MEDICAL EQUIPMENT

Medicare requires us to inform you that you have an option to either rent or purchase inexpensive or routinely purchase medical equipment. These items have a purchase price of less than $150. Medicare has classified walkers, quad canes, crutches, wheelchair cushions and commode chairs as inexpensive or routinely purchased medical equipment.

EXPLANATION OF CAPPED RENTAL BENEFITS

Some equipment (wheelchair, hospital bed, nebulizer, PAP unit, etc.) is paid under a capped rental format. Medicare and some other insurances will pay for rental for 13 months and then the equipment becomes yours. This means that during the 13 months you or your secondary insurance will be responsible for the 20% co-pay monthly until the cap has been reached. The Company is responsible for maintenance and service needed during the 13 months. Once the 13-month payment is completed it will then become your responsibility for all maintenance, service, repair, or replacement parts. You will be informed before delivery if the equipment ordered by your physician is rental under this format.

COLLECTIONS NOTICE

It is the policy of the Company, upon default, to send patient accounts to third parties for the purpose of collection. At that point the patient/responsible party is liable for all costs associated with the recovery of the defaulted account, including but not limited to attorney and all collection fees.

USUAL AND CUSTOMARY RATES

Our company is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. We are an in-network provider for the majority of insurance companies and work out fee schedules with them in accordance with what is usual and customary for them.

QUALITY OF SERVICE PROCEDURE

If you have a question regarding the quality of service, you received contact us at:

815-694-2619

Or you may contact:

Accreditation Commission for Health Care (ACHC)
139 Weston Oaks Ct.
Cary, NC 27513
(919) 785-1214

CPAP/BiPAP SUPPLIES BILLING

Below is an outlined description of the billing procedures to assist you in better understanding a statement from our company:

- Headgear is replaceable every 6 months; however, typically most masks have the head gear attached. Therefore, you may see a bill statement where headgear has been charged but onthe next bill statement you will not see that charge.

Some insurances require authorization or predetermination before you can receive replacement supplies the same day. This process can take 2-4 weeks depending on the response time of your insurance. Please check with your insurance carrier if you have any questions.

CPAP/BiPAP SUPPLIES REPLACEMENT

The following is a general guideline for replacement supplies that are typically covered by insurance. However, every insurance is different so if you have questions, please be sure to contact your insurance company or our supply department @ (601)891-1669

Description	Qty/Frequency
Mask (nasal, full face, or oral)	1 per 3 months for Medicare (some plans allow 1 per 6 months)
Cushions (full face, or oral)	1 per month (not billable same month as mask)
Cushions, each (nasal)	2 per month (not billable same month as mask)
Pillows per pair (nasal)	2 per month (not billable same month as mask)
Headgear	1 per 6 months for Medicare (some plans allow 1 per 3 months)
Chinstrap	1 per 6 months for Medicare (some plans allow 1 per 3 months)
Tubing, any type or size	1 per 3 months
Filter, non-disposable	1 per 6 months for Medicare (some plans allow 1 per 3 months)
Filter, disposable	2 per 1 month for Medicare (some plans allow 1 per 3 months)
Chamber for PAP humidifier device	1 per 6 months

NOTICE OF PRIVACY RIGHTS

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Company is dedicated to protecting your medical information. We are required by law to maintain the privacy of protected health information and to provide you with this Notice of our legal duties and privacy practices with respect to protected health information. We are required by law to abide by the terms of this Notice.

We will use your medical information in supplying healthcare-related products. For example, your medical information may be used by our employees and your treating physician, by the business office to process your payment for the services rendered and by administrative personnel re- viewing the quality of care you receive. Your medical information may also be used, as necessary, to contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest of you. For example, your name and address may be used to send you a newsletter about health-related products offered by our company, new or alternative treatments, health re- sources, and other information related to your health. We may also use and/or disclose your information in accordance with federal and state laws for the following purposes:

Personal Representatives—If your personal representative has the authority by law to act on your behalf in making decisions related to your health care, we may disclose your medical information to him or her. We may require your personal representative to produce evidence of his or her authority to act on your behalf. In the event of your death, an executor, administrator, or other person authorized under the law to act on behalf of you or your estate will be treated as your personal representative.

Family and Friends—Unless you object, we may use and/or disclose your medical information to family members, other relatives or close personal friends when the medical information is directly relevant to that person's involvement with your care.

Notification—Unless you object, we may use and/or disclose your medical information to notify a family member, a personal representative or another person responsible for your care of your location, general condition or death.

Public Health Activities—We may use and/or disclose your medical information for public health activities and safety, for purposes relatedto controlling disease, injury, or disability.

Disclosure to Department of Health and Human Services—We may use and/or disclose medical information when required by the United States Department of Health and Human Services as part of an investigation or determination of our compliance with relevant laws.

Research—We may use and/or disclose your medical information for certain research purposes if an Institutional Review Board or a privacy board has altered or waived individual authorization, the review is preparatory to research or the research is on only decedent's information.

Health Oversight Activities—We may use or disclose your medical information for public health activities, including the reporting of dis- ease, injury, vital events and the conduct of public health surveillance, investigation and/or intervention. We may disclose your medical information to a health oversight agency for oversight activities authorized by law, including audits, investigations, inspections, licensure or disciplinary actions, administrative and/or legal proceedings.

Abuse or Neglect—We may disclose your medical information when it concerns abuse, neglect or violence to you in accordance with federal and state law.

Legal Proceedings—We may disclose your medical information in the course of certain judicial or administrative proceedings.

Law Enforcement—We may disclose your medical information for law enforcement purposes or other specialized government functions.

Coroners, Medical Examiners and Funeral Directors—We may dis- close your medical information to a coroner, medical examiner or funeral director to carry out their duties.

Organ and Tissue Donation—If you are an organ donor, we may use and/or disclose medical information to organizations that handle organ procurement or organ, eye or tissue donation or transplantation.

Disaster Relief—We may disclose your medical information to a public or private entity, such as the American Red Cross, for the purpose of coordinating with that entity to assist in disaster relief-efforts.

Public Safety—We may use and/or disclose your medical information to prevent or lessen a serious threat to the health or safety of another person or to the public.

Workers' Compensation—We may disclose your medical information as authorized by laws relating to workers' compensation or similar pro- grams.

Inmates—We may release medical information about inmates to correctional institution or law enforcement officials, as necessary to provide the inmate with health care, to protect the health and safety of the inmate or others, or for the health and safety of the correctional institution.

Military and Veterans—We may release medical information as re- quired by military command authorities, and as applicable, to appropriate foreign military authorities.

Business Associates—We may disclose your health information to a business associate with whom we contract to provide services on our behalf. To protect your health information, we require our business associates to appropriately safeguard the health information of our customers.

NON-DISCRIMINATION POLICY AND COMPLAINT PROCEDURE

the Company provides a process for patients/clients to lodge an oral, written, or telephone complaint about the products and services provided. The Company has a complaint resolution system for identifying, responding to, and resolving complaints in a timely manner. Patients or caregivers who wish to voice a complaint regarding our products or services should provide the following information:

- Name of patient/client or caregiver voicing the complaint.
- A summary of the complaint, including the date of service.

Upon receiving a complaint and/or grievance the company will:

- Notify the appropriate employee (s)
- Contact the patient/client or caregiver within 5 business days if unable to resolve when the complaint is received.
- The patient/client or caregiver who filed the complaint has the right to call the Medicare Hotline (1-800Medicare), Tennessee Department of Health Division of Health Care Facilities Centralized Complaint Intake Unit (1-877-287-0010) or ACHC (our accrediting organization) (1-919-785-1214) if they are not satisfied with our response.

Medicare Providers:

Within five (5) calendar days of receiving a patient/client complaint, the Company notifies the patient/client, using either oral, telephone, e-mail, fax, or letter format, that it has received the complaint and that it is investigating. Within 14 calendar days, the Company, Inc provides written notification to the person making the complaint of the results of the investigation and response. The Company, maintains documentation of all complaints that it receives, copies of the investigations, and responses provided to those making the complaint. Records may not be available after 3 years. If a patient is not satisfied with the Company, they can contact the Medicare Hotline at 1-800- Medicare or 1-800-633-4227, they can also contact ACHC at 1-919-785-1214 (ask for the complaints department).

USE AND DISCLOSURE OF HEALTH INFORMATION AUTHORIZATION

I hereby authorize the use and/or disclosure of my name, photograph and/or written, audio-taped, or videotaped testimonials, by the Company, as described below:

- To government officials, for the purpose of providing information about the Company's impact on its customers' lives to the government officials.
- To the Company for its own use for internal training purposes and internal company communications, which may include use in the Company's internal newsletter and training materials. To the public and employees at the Company's facilities for the purposes of communicating about
- The Company's products and/or services.

Neither I nor the Company will receive any financial or in-kind compensation in exchange for using or disclosing my name, photograph and/or testimonials. I understand that this authorization is voluntary, and that the Company will not condition treatment or payment for health care services on my completion and signing of this Authorization. This authorization will expire upon revocation by me.

CUSTOMER BILL OF RIGHTS

As an individual receiving home care services, 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 company who provides treatment or services for you and be free from neglect or abuse, be it physical or mental.
5. To have your property treated with respect by each and every individual representing the company who provides treatment or services for you.
6. To be fully informed concerning, and to assist in the development and planning of, your home care program so that it is de- signed to satisfy, as best as possible to your current needs.
7. 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.
8. To express concerns or grievances or recommend modifications to your home care service without fear of discrimination or reprisal.
9. To request and receive complete and up-to-date information relative to your condition, treatment, alternative treatments, and risks of treatment.
10. To receive timely responses to request for home care equipment, treatment, and services within the scope of your home care plan, promptly and professionally, while being fully informed as to company policies, procedures, and charges, including those for which you are responsible and those for which our insurance is responsible.
11. 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.
12. To request and receive the opportunity to examine or review your medical records.
13. Participate in the consideration of ethical issues that may arise during your care.
14. To have the confidentiality of all of the information in your medical record maintained.
15. To receive an explanation of all forms you have signed that were presented by the Company.
16. To be provided with the manufacturer's specifications and warranty information.

*Note: The Company's delivery personnel are not medically qualified to provide resuscitation in the event of a medical emergency, however we would utilize "911" services (EMS) for emergencies.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

- You have the right to ask us to restrict certain uses and disclosures of your medical information for treatment, payment or health care operations. We are not required to agree to your request.
- You have the right to receive communications from us in a confidential manner.
- Generally, you may inspect and copy your medical information. This right is subject to certain specific exceptions, and you will be charged $30.00 for copies of your records.
- You may ask us to amend your medical information.
- You may request a paper or electronic copy of this Notice of Privacy Practices for Protected Health Information.
- You have the right to receive an accounting of the disclosures of your medical information made to the Company, during the last seven years except for disclosures for treatment, payment or healthcare operations, disclosures which you authorized and certain other specific disclosure types.
- You have the right to complain to us and/or to the United States Department of Health and Human Services if you believe that we have violated your privacy rights.
- If you choose to file a complaint, you will not be retaliated against in any way.

If you would like to submit a complaint or request additional information regarding your rights or regarding the uses and disclosures of your medical information, you may contact:

OrthoMotion
ATTN: Privacy Officer 1100
Hatcher Lane Columbia, TN 38401
1-800-722-7313

We reserve the right to change the terms of this Notice, making any revision applicable to all the protected health information we maintain. If we revise the terms of this Notice, we will post a revised notice at the Compnay and will make paper copies of the revised Notice of Privacy Practices available upon request.

We will not use or disclose your medical information for any other purpose without your written authorization. Once given, you may revoke your authorization in writing at any time

CMS 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) http://www.ecfr.gov

1. A supplier must be in compliance with all applicable Federal and State licensure and regulatory requirements.
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. A 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 and maintain a visible sign with posted hours of operation. The location must be accessible to the public and staffed during posted hours of business. 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 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. Suppliers are prohibited from direct solicitation to Medicare beneficiaries. For complete details on this prohibition see 42 CFR § 424.57 (c) (11).
12. A supplier is responsible for delivery of and must instruct beneficiaries on use of Medicare covered items and maintain proof of delivery and beneficiary instruction.
13. A supplier must answer questions and respond to complaints of the beneficiaries and maintain documentation of such contacts.
14. A supplier must maintain and replace at no charge or repair cost either directly, or through a service contract with another company, any 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 standards to each beneficiary it supplies a Medicare-covereditem.
17. A supplier must disclose any person having ownership, financial, or control interest in thesupplier.
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 for those specific products and services (except for certain exempt pharmaceuticals).
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. A supplier must meet the surety bond requirements specified in 42 C.F.R. § 424.57 (d).
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. A supplier is prohibited from sharing a practice location with other Medicare providers and suppliers.
30. A supplier must remain open to the public for a minimum of 30 hours per week except physicians (as de- fined in section 1848(j) (3) of the Act) or physical and occupational therapists or a DMEPOS supplier working with custom made orthotics and prosthetics.
    warranties and hours of operation). The full text of these standards can be obtained at http://www.ecfr.gov

ADVANCE DIRECTIVES POLICY

Advance Directives are instructions to let family, caregivers, physicians, and healthcare providers know your decisions for health care if you become unable to decide for yourself. They include written instructions regarding resuscitation and withholding or withdrawing treatment. These directives may include, but are not limited to, designating another person to make medical decisions for you should you become unable to make these decisions. Care will not be withheld if an Advanced Directive is not present.

You or your caregiver(s) should discuss the Rights and Responsibilities of Advance Directives with your physicians and obtain a specific form signed by all responsible parties involved.

The Company's employees are instructed not to perform CPR and therefore no training is required. Our employees are instructed to follow these steps in the event of an emergency:

- Call 911 if indicated
- Notify the appropriate Company supervisors
- Provide support and help to the patient/client family
- Document actions in the patient/client record
- Complete an incident report

CODE OF ETHICS STATEMENT

- We always strive to provide the highest quality services to our clients/patients while meeting the highest professional and ethical standards possible.
- We provide home medical equipment and services in a prompt and reliable manner, ensuring that the equipment and services are safe and meet the client/patient's health care needs.
- We do not discriminate, either regarding clients/patients or employees, on the basis of any characteristic prohibited by law.
- We conduct our business professionally and ethically and set up mechanisms to prevent fraud.
- We apply the highest standards of integrity in our advertising, marketing, and billing practices.
- We treat our clients/patients with respect, support their freedom of choice, and ensure that they are aware of their rights and responsibilities.
- We instruct each patient/client and/or caregiver in the correct operation of the equipment and service provided.
- We protect the confidential nature of client/patient health care records.
- We provide the appropriate insurance liability coverage for employees and clients/patients.
- We also provide Worker's Compensation.
- We screen staff via several means, including professional reference checks, before offering employment, and ensure that all staff members continue to improve their knowledge and skills so that the Company is able to provide home medical products and services competently.
- We provide employee orientation and continuing education opportunities to ensure that staff skills are current.
- We comply with all relevant federal, state, and local laws and regulations, as well as the requirements of federal, state, and private-payer health care programs and Accreditation Commission for Health Care.

CPAP/BiPAP/Power Mobility Documents

What is Obstructive Sleep Apnea?

Sleep Apnea is a potentially serious sleep disorder in which breathing repeatedly stops and starts during sleep. Several types of sleep apnea exist, but the most common type is obstructive sleep apnea, which occurs when your throat muscles intermittently relax and block your airway during sleep. The most noticeable sign of obstructive sleep apnea is snoring, although not everyone who has obstructive sleep apnea snores. Common symptoms are excessive daytime sleepiness (hypersomnia), loud snoring, observed episodes of breathing cessation during sleep, abrupt awakenings accompanied by shortness of breath, awakenings with dry mouth or sore throat, morning headache, frequent urination at night, and difficulty staying asleep (insomnia). Your doctor felt that you may suffer from this condition, so you were sent to a Sleep Lab for further evaluation. A sleep study consists of 1 or 2 different studies: a PSG, which is the diagnostic portion and a titration which is the portion where your pressure was determined. During the PSG it was determined that you had sleep apnea. You could have had a split night study if your study was recognized as severe. A split night study is where they watched you for a couple of hours and then began your titration.

- Untreated apnea is associated with several medical conditions including but not limited to:
- High blood pressure
- Heart disease
- Heart attack
- Irregular heart beat
- Stroke
- Type 2 diabetes
- It is important to note the OSA may also contribute to driving and work-related accidents.
- PAP therapy will relieve the airway obstruction while you sleep. It acts as an air splint to keep the airway open so that you can sleep throughout the night without interruption. By wearing your machine all night every night, you may see these positive benefits from therapy:
- Increased energy level and attentiveness
- Reduced irritability
- Improved memory
- Less waking during the night to go to the bathroom
- Increased ability to exercise
- Increased effectiveness at home or work
- Fewer morning headaches

Most patients who start PAP therapy are on it long term. Things that may affect your pressures or need for PAP therapy include surgery and weight loss. You are to notify your physician if you have any of the above.

PAP EXPECTATION PLAN

Your physician has recently ordered you a PAP device used during sleep for the treatment of obstructive sleep apnea. According to insurance guidelines you qualify for this equipment and your doctor has asked us to set this up for you.

We have outlined the guidelines issued by your insurance company below. These are guidelines that you must follow in order for your insurance to pay for the equipment ordered by your physician. Please read them carefully. Failure to follow these requirements can result in payment denial from your insurer. In such a case, you will be responsible for payment of your bill.

- After you have used the device for at least 30 days, but no longer than 90 days, you will need to go in and see your doctor. Your doctor must re-evaluate you to see that you are benefiting from the use of the PAP therapy. In this re-evaluation, there must be documentation that your symptoms of obstructive sleep apnea have improved through use of this device.
- Your physician may or may not have downloading capabilities. If your physician does and you visit your physician between days 31-90, you are not required to see our therapist. However, you need to call our office and let us know.
- Due to the guidelines set forth by your insurance company, it is imperative that the above steps are followed. If after day 90 you are not meeting the requirements set by insurance (which is greater than 4 hours nightly 70% time over last 30 days), then you will be required to go back and have new sleep studies to keep the equipment. So, it is very important that you help us obtain the goals for payment that your insurance has set out.
- If you do not follow up with your physician and we are unable to get the information required by your insurance company, you will be responsible for the monthly rental of the equipment. This rental is as follows: $200.00 monthly for the CPAP device and $400 monthly for the BiPAP device. Please note that the insurance will not pay for supplies during this time if you are not compliant with the above steps to continue PAP therapy.
- When signing for receipt of this book you state that you understand that our monitoring activities as described above are solely for insurance qualification purposes. The monitoring services do not serve any clinical purposes, and we are not assuming responsibility for any clinical review or supervision.

When signing for receipt of this book you are further stating that you understand the insurance policy for continued coverage of PAP therapy, and you will comply with the set guidelines. If you do not follow the set guidelines, you understand that you will be responsible for the payment of the devices and any supplies requested. You are also stating that we will be able to reach you via the contact information you have supplied us with. You are responsible for providing us with the correct contact information.

Tips when using the PAP device:

Don't overtighten your headgear. To help relieve undue pressure on the bridge of your nose, try to correct the problem by tightening the bottom straps first. You may see the need to increase tightening your straps because your cushion is wearing out. If this is the case, contact us to see about replacing your cushion or your mask. This will help to prevent over tightening, which leaves red marks on your face.

If your mask is leaking, this may affect your pressure thus making the CPAP / BiPAP ineffective. Please let us know if you have any problems with your mask leaking.

If you experience nasal stuffiness, ear, nose sinus or eye pain, please contact us. If you have problems with your mask or the machine, please call us.

It is very important to the life of your CPAP that your filters are changed as recommended by the manufacturer's guidelines. If they are not changed properly, the machine will be affected. If you need a loaner machine and your supplies have not been maintained, there will be a fee of $200.00 per month for the CPAP and $400.00 for a BiPAP.

To make sure to keep respiratory infections down to a minimum, please wash your tubing, mask and water chamber as listed previously. Please change them when needed as directed by the attached insurance guideline.

It is important to replace your PAP equipment on a regular basis, especially your mask and tubing. Old masks, tubing and filters wear out and your equipment may not be as effective as possible.

You may awaken in the night with the tube full of water or hear a banging noise. This noise occurs when the air pressure is trying to blow over a puddle of water in the tube and usually indicates the need to turn down your humidifier setting. You'll also want to dry out your tube during the day by hanging it over a door so that the air can circulate throughout the tube. If moisture still resides inside, attach the tube to your CPAP and let it blow through for a few minutes. You may have been insulating the tube during the winter months in order to stop condensation. Remove the covering until the fall and enjoy the spring season!

Getting a rash or redness from your mask? It could be you are wearing it too tight, not cleaning it well enough or it may be wearing out.

Even the highest grade of mask will cause skin irritation when it's nearing the end of its life span. When you are wearing your mask nightly, it will eventually wear out over time. When the cushion of a mask's flexibility degrades, the risk of leaks also increases.

PAP Cleaning Instructions:

The Company's therapy department primarily uses one of three manufacturer's machines. We use machines made by ResMed, Philips Respironics, and ReactHealth, All machines are at the top of the market. Your doctor may prefer one over another. We will set up the one that your physician has ordered, if possible. Please let us know if you have a preference of machine. The therapist has indicated below which machine you have received. Please follow the filter cleaning instructions for the machine indicated below:

Philips/Respironics:
Check your filter weekly. If your machine contains a white disposable filter, change it when it appears discolored.

ResMed:
Check weekly. Change every 2 weeks if needed. Do Not Wash.

ReactHealth:
Check weekly. Change every 2 weeks if needed. Do Not Wash.

Mask: Wash the cushion of your mask daily with warm soapy water. Please be sure to use a mild soap with no moisturizers added or a face wash cloth with no oil. Make sure to wash your face before putting on the mask. Do not use moisturizers. The oils from the moisturizers and the natural oils from your skin will break the cushion down on the mask. Once per week wash the entire mask in warm soapy water using a mild detergent.

Headgear: Hand-wash your headgear as needed. Let it air dry. Do not put it in the dryer.

Tubing: Check your tubing daily for water condensation from your humidifier. Empty the tubing as needed. Once per week soak your tubing in warm soapy water using a mild detergent. Let it air dry. It is suggested to change your tubing at least every three months to prevent upper respiratory infections.

Humidifier Chamber: Use distilled water **ONLY** in your humidifier. Empty it daily. Once per week wash the unit in warm soapy water using a mild detergent.

ORTHOMOTION technology

For Your Reference Are All Forms Signed at Delivery Following This Page (if applicable).

family home MEDICAL

ORTHOMOTION technology

Mobility Home Assessment Form

Patient Information

Name: DOB:

Type of Residence

☐ Single Story	☐ Multi-Story	☐ Apt./Condo	☐ Mobile Home

Handicap Accessible:	☐ Yes	☐ No

Home Environment

Area	Accessible with Equipment	Door Width	Surfaces	Able to Traverse Thresholds
Entrance	☐ Yes ☐ No		☐ Carpet ☐ Hardwood ☐ Linoleum ☐ Tile	☐ Yes ☐ No
Living Room	☐ Yes ☐ No		☐ Carpet ☐ Hardwood ☐ Linoleum ☐ Tile	☐ Yes ☐ No
Kitchen	☐ Yes ☐ No		☐ Carpet ☐ Hardwood ☐ Linoleum ☐ Tile	☐ Yes ☐ No
Hallway	☐ Yes ☐ No		☐ Carpet ☐ Hardwood ☐ Linoleum ☐ Tile	☐ Yes ☐ No
Bedroom	☐ Yes ☐ No		☐ Carpet ☐ Hardwood ☐ Linoleum ☐ Tile	☐ Yes ☐ No
Bathroom	☐ Yes ☐ No		☐ Carpet ☐ Hardwood ☐ Linoleum ☐ Tile	☐ Yes ☐ No

Question	Answer
Is there sufficient room throughout the patient's home to allow the patient to perform MRADLs using the equipment?	☐ Yes ☐ No
Are there any factors such as temperature, physical layout, surfaces, or obstacles that will render the equipment unusable in the beneficiary's home?	☐ Yes ☐ No

Supplier Attestation

I have completed an assessment of the patient's home and attest all areas, doorways, and surfaces of the patient's home will fully accommodate the following equipment:

☐ CPAP/BiPAP ☐ CPAP/BiPAP Supplies ☐ POV/Power Chair ☐ BiPAP ☐ Other

Supplier Signature:______________________________ Date: ______________

Supplier Printed Name: ______________________________

PAYMENT AUTHORIZATION

I authorize payment of medical benefits to the Company, for services prescribed by my treating physician.

MEDICAL RELEASE INFORMATION

I authorize the release of any medical or other information necessary to the Company, to process the CMS-1500, Health Insurance Claim Form. I also request payment of government benefits either to myself or the party who accepts assignment on my claim (affirm by signing below) *.

ADJUSTMENT PERIOD

The Company is committed to helping you maintain independence. As such, sometimes adjustments and/or comfort adaptations are needed. If such occurs, we offer a 7 (seven) day grace period in which we will adjust the equipment as needed to try and obtain satisfaction. If you fail to notify our office within the 7 (seven) day window, then the normal service call applies as outlined next. By signing below, you acknowledge you are aware of the Adjustment Period. *

WHEELCHAIR SERVICE INFORMATION (if applicable)

The product(s) you are receiving are being purchased by your insurance, or by you. **As a result, the Company transfers the title of this equipment to you.** Thus, you are responsible for any service that should be required. We offer service for this equipment that is provided. You may bring the equipment to one of our locations and the equipment can be serviced there. If you cannot bring the equipment to a location and wish for a service technician to make a house call, then we will arrange to make the service call when a technician is in your area. If you have an emergency, you should call 911. If you are outside of our normal coverage area, you may be responsible for the trip charge. You will be responsible for getting the appropriate prescription and such as needed in order to file a claim to your insurance for repairs to your equipment. The Company will provide the service and submit the claim for you and your insurance will reimburse the Company for any repairs that are needed that are not due to neglect and/or abuse. If the part is still under warranty, then the Company will replace the part under warranty. **Please note that warranty does NOT cover parts due to neglect and/or abuse**.

EQUIPMENT ORIENTATION CHECKLIST/PLAN OFCARE

CPAP, BiPAP, RAD

Patient Name: ____

Patient was educated on the following:
How to turn on the unit
Wipe the unit down with a clean, dry cloth to wipe away debris
Changing the filters
When to change out supplies
Making sure the humidifier chamber is empty before packing the machine to travel.
Data card/Modem
Keeping extra supplies on hand
Adjusting the temp setting on the humidifier
Adjusting the Ramp on the unit
Advance Directives ___Yes ___No
Pressure settings are not adjustable without a prescription from the physician

Type of Machine:_____________________**Settings:**__________**Supplies:**_____________________

Patient gave a return demonstration of all components of equipment and supplies successfully.

Patient had the following concerns about their equipment and/or supplies at time of setup:
____

Patient was instructed to bring their card/machine with them to all of their appointments with their sleep physicians.

Patient voiced understanding on how to appropriately clean their machine and supplies.

Patient was given handout/education about replacement supplies and how to get them and how often. They were signed up in S3 Resupply program with the Company.

Patient was educated on proper mask fit.

Patients understand they are involved in their plan of care with physician and the Company. They are responsible for assisting with getting adherence data to the Company/physician in one week, one month, 3 months, 6 months, and 12 months. Failure to comply with these protocols could lead to non-coverage of their machine and supplies. In addition, they were educated that any time a physician changes a prescription on their equipment they need to get another download immediately to assess effectiveness of the new pressure.

Patient was educated to contact OUR office if they have any issues/problems that arise, and we will communicate with physician to rectify any and all situations.

Patient was placed in Airview, iCode Connect or Care Orchestrator and linked to a sleep lab with wireless modem.

GOALS	PLAN - ACTIONS
1. Initial equipment/supplies services with above listed.	1. Setup equipment/supplies in home and/or facility. Evaluate suitability and assure safe placement of equipment/supplies.
2. Patient/Caregiver trained to operate equipment/supplies in safe manner.	2. Setup equipment/supplies in home and/or facility. Evaluate suitability and assure safe placement of equipment/supplies.
3. Patient/Caregiver understands cleaning, troubleshooting and treatment guidelines for equipment/supplies.	3. Instruct patient/caregiver in cleaning, troubleshooting and treatment guidelines. Reinforce each follow-up.

By signing this form, I, the patient, am expressing that I fully understand the treatment protocol that the Company and my sleep physician have lined out for me. I understand all of the procedures above and will comply with them to my fullest extent.

_____________________________________ _____________________________

Patient **Date**

CONSENTS AND ACKNOWLEDGEMENTS

______(initials) Medicare or my insurance has not purchased or rented same/similar items as I am receiving within the last 5 years for PAP devices and/or within the last 3 months for PAP supplies.

______(initials) I received explanation and understand that Medicare defines the PAP unit that I received as being a CAPPED RENTAL. This means that Medicare will pay a monthly rental fee or a period not to exceed 13 months, aer which ownership of the equipment is transferred to the Medicare beneficiary. After ownership is transferred, it is the beneficiary's responsibility to arrange for any service or repairs.

______(initials) Other insurance plans (including Medicare Advantage Plans) have their own rules and regulations regarding rental vs. purchase. I have been informed of my specific insurance plan's policy.

______(initials) Potential Split Billing Through Your Insurance: I understand that I was made aware of how my insurance may process PAP resupplies with span- dates. My understanding is that I may receive a 3-month supply of supplies in one package or at setup, but they are billed in 3 separate months. Example of billing is listed below:

- Month 1 (Mask, Headgear, Tubing, & 2 Filters) or (1 Seal/2 Cushions/2 Pillows, Tubing & 2 Filters)
- Month 2 (Replacements - 1 Seals/2 Cushions/2 Pillows & 2 Filters)
- Month 3 (Replacements - 1 Seal/2 Cushions/2 Pillows & 2 Filters)

______(initials) I attest that I have been given information and direction to obtain an electronic copy of our Company's Customer Welcome Guide on our company's website at www.orthomotiontech.com.

______(initials) I consent to receive emails, phone calls, and text messages for communication related to appointments and other company communications. Some messages relevant to your equipment/supplies may be sent regardless of explicit consent, including instructions or communications directly related to your care. These instructions may include, but are not limited to follow-up instructions, educational information, and prescription information. For other types of communications, I consent to receiving, by telephone call, text message or voicemail transmission, communications by or on behalf of the Company via telephone number or text address I have provided in my patient record. I also consent to receiving such communications to any email, text address or telephone number forwarded or transferred from that address or telephone number. Other healthcare communications may include, but are not limited to, healthcare communications to family or designated representatives regarding my treatment or condition, reminder messages to me regarding appointments for medical care, communications regarding insurance or billing or requests for feedback about my visit via satisfaction surveys and/or public-facing reviews, and requests to re-order equipment and supplies. I authorize and acknowledge that these instructions and other communications may be transmitted using an automated system for the selection or dialing of telephone numbers or the playing of prerecorded messages and may be made by the company or someone calling on their behalf even if my phone number is listed on any federal or state "do not call" registry. To the extent these instructions and other communications could be deemed telephonic sales calls, solicitations, or advertisements, I consent in receiving them. I understand that I am not required to consent directly or indirectly to communications in order to receive healthcare services.

______(initials) **CPAP and BIPAP Patients**: I understand that the Company's clinical support services are available for CPAP and BiPAP Monday - Friday from 8:30 AM - 4:00 PM local branch time - excluding holidays. Should you have a medical emergency, please immediately call 911 or seek immediate emergency assistance. Our clinical support services do not offer medical advice or services, and we waive any and all responsibility for maters requiring professional medical attention. If you need assistance after normal business hours, your call will be returned the next business day.

By signing this form, I am stating that I have been fully instructed and understand how to operate the equipment prescribed to me and that I have been instructed on the plan of care. I have also been given information and direction to obtain an electronic copy of our Company's Customer Welcome Guide on our company's website at www.orthomotiontech.com, which includes the following:

- Notice of Privacy Rights/PHI Use and Disclosure
- DMEPOS Medicare Supplier Standards
- Patient Rights and Responsibilities
- Business Hours and Branch Contact Information
- Warranty Information
- Complaint Reporting Procedure
- Emergency Preparedness
- Patient Financial Responsibility
- Medicare and ACHC Contact Information
- Equipment Orientation Checklist
- Advance Directives Policy
- Code of Ethics Statement

Signature: ____

Date: ______________________________

p. 1-601-898-3774

OrthoMotion / Family Home Medical
Payment Policy & Authorization

The Company ("OrthoMotion/Family Home Medical") requires a form of payment (such as a credit card or bank account information) on file to satisfy any balances for equipment or services that are not paid by insurance. This will include the patient portion of any rental charges incurred in future months. All account information is confidential and securely stored by the PCI-compliant merchant processor.

After insurance pays its portion of the bill, an email statement will be sent by the Company, outlining the amount owed. Fifteen days later, the amount owed will be charged to the account on file. This will occur monthly if the insurance company chooses to rent the equipment instead of buying it.

Patients being discharged from the hospital often do not have credit cards with them. In order to provide you with the Company equipment today, you must agree to provide credit card or bank information to the Company within 5 working days.

Authorization for Automatic Payment

I hereby authorize the Company: to regularly charge my credit card and/or bank account for any balances for equipment and services owing by me to you that are my responsibility; and to initiate adjustments for any transactions debited or credited in error. I agree that no prior notification will be provided, and I agree that it is my responsibility to ensure that there are sufficient funds in the bank account or credit availability on the credit card.

FOR BANK WITHDRAWALS ("ACH"), I UNDERSTAND THAT BECAUSE THESE ARE ELECTRONIC TRANSACTIONS, THESE FUNDS MAY BE WITHDRAWN AS SOON AS THE PERIODIC TRANSACTION DATES SET FORTH HEREIN. IN THE CASE OF AN ACH TRANSACTION BEING REJECTED FOR INSUFFICIENT FUNDS (NSF), OR CREDIT CARD DECLINE, I AGREE THAT THE COMPANY MAY AT ITS SOLE DISCRETION ATTEMPT TO PROCESS THE CHARGE AGAIN, AND I AGREE AN ADDITIONAL CHARGE FOR EACH ATTEMPT WILL BE INITIATED AS A SEPARATE TRANSACTION FROM THE AUTHORIZED RECURRING PAYMENT. BY SIGNING BELOW, I AFFIRM THAT I AM AN AUTHORIZED USER OF THE CREDIT CARD/BANK ACCOUNT PROVIDED AND WILL NOT DISPUTE THESE SCHEDULED TRANSACTIONS WITH THE BANK OR CREDIT CARD COMPANY SO LONG AS THE TRANSACTIONS CORRESPOND TO THE TERMS INDICATED IN THIS AUTHORIZATION FORM OR ANY UNDERLYING AGREEMENT.

I WILL BE INVOICED FOR ALL SERVICES AND PRODUCTS PROVIDED AS WELL AS SUCH TAXES AS ARE MANDATED BY LAW AND A CREDIT CARD TRANSACTION FEE OF 3%. THE COMPANY RESERVES THE RIGHT AT ITS SOLE DISCRETION TO SUSPEND SERVICES FROM ME, WITH OR WITHOUT TERMINATING ANY AGREEMENT, SHOULD THERE BE ANY FAILURE TO PAY BY ME WITHIN THE TERMS AND CONDITIONS OF ANY AGREEMENT. I HEREBY RELEASE THE COMPANY FROM ANY AND ALL LIABILITY FOR ANY DIRECT OR INDIRECT CLAIMS DUE TO OR ARISING FROM MY FAILURE TO TIMELY PAY THE COMPANY'S INVOICES.

I hereby authorize the Company to regularly debit my bank account or charge my credit card on a recurring basis for payment as detailed in any Agreement.

Authorizing Signature: ____________________________________Date: _______________________

Print Name: ____

Patient Name:
Equipment:
Date:

Patient Satisfaction Survey

1. Was the equipment/service provided in a timely manner?
❑Strongly Agree ❑ Agree ❑ Neither Agree nor Disagree ❑Disagree ❑Strongly Disagree

2. Were you provided instructions on your equipment/care?
❑Strongly Agree ❑ Agree ❑ Neither Agree nor Disagree ❑Disagree ❑Strongly Disagree

3. Were all your questions answered to your satisfaction?
❑Strongly Agree ❑ Agree ❑ Neither Agree nor Disagree ❑Disagree ❑Strongly Disagree

4. Were you instructed on who/where to call with questions or problems?
❑Yes ❑No

5. Were you satisfied with your equipment/service?
❑Strongly Agree ❑ Agree ❑ Neither Agree nor Disagree ❑Disagree ❑Strongly Disagree

6. Were you satisfied with your Delivery Technician?
❑Strongly Agree ❑ Agree ❑ Neither Agree nor Disagree ❑Disagree ❑Strongly Disagree

7. Please tell us who your Delivery Technician was___________________________

8. Were you satisfied with your Customer Service Representative?
❑Strongly Agree ❑ Agree ❑ Neither Agree nor Disagree ❑Disagree ❑Strongly Disagree

9. Please tell us who your Customer Service Representative was_______________________

10. Did you receive a copy of the Patient's Rights & Responsibilities?
❑Yes ❑No

Please share your comments or suggestions on how we might serve you better.

____

____