Liberty Health Supply, Inc.
CLIENT/PATIENT SERVICE AGREEMENT

Client/Patient Name: _____ Facility _____

Authorization/Consent for Care/Services: I authorize Liberty Health Supply, Inc., to provide HME/DME as prescribed by my physician for enteral feeding, ostomy, tracheostomy, wound care and urological supplies. I further certify that information given by me in applying for payment under Title XVIII of the Social Security Act is correct.

Assignment of Benefits/Authorization for Payment: I hereby authorize that benefits/payments be made directly to Liberty Health Supply, Inc. for any supplies furnished to me while residing in the above named facility. I authorize Liberty Health Supply, Inc. to seek such benefits/ payments on my behalf. It is understood that, as a courtesy, Liberty Health Supply, Inc. will bill Medicare/Medicaid and any insurer(s) providing coverage. I understand that I am responsible for providing all necessary information and for making sure all certification and enrollment requirements are fulfilled. Any changes must be reported to Liberty Health Supply, Inc. within 30 days of the event. I understand that in the event that services prescribed/ordered by my physician are deemed not reasonable and necessary, payment may be denied and that I may be fully responsible for payment.

Release of Information: I hereby request and authorize the ordering physician, hospital, nursing facility and any other holder of information relevant to my care or payment for such, to release information to Liberty Health Supply, Inc. and any payor source, physician, or other medical personnel or agency involved with my care. I also authorize Liberty Health Supply, Inc. to review medical history and payor information for the purpose of providing HME/DME.

Financial Responsibility: I understand and agree that l 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. All charges not paid within 45 days of billing date shall be assessed late charges equaling 1.5% per month. I am responsible for all charges regardless of my payor 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/supplied cannot be re-dispensed; therefore, cannot be returned for credit. Equipment that is rented will be returned after the physician has discontinued service. Liberty Health Supply, 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.

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 and HIPPA Privacy Standards. I acknowledge that the information in the Client/patient Handouts has been provided to me and that I understand the information.

Grievance Reporting: I acknowledge that I have been informed of the procedure to report a grievance should I become dissatisfied with services provided. I understand that I may lodge a complaint by calling 585-235-1370 and speaking to the Customer Services Supervisor. If my complaint is not resolved within 5 working days, I may initiate a formal grievance in writing and forward it to the Director of Finance & Reimbursement. A written response will be issued within 7 working days of receipt. If not satisfied you may contact NYS Division of Consumer Protection at 800-697-1220 or ACHC.

Plan of Service: 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.

Home Health Hotline: You may also make inquiries or complaints about this company by calling Medicare at 800-633-4227 and/or ACHC (Accreditation Commission for Healthcare, Inc.) at 919-785-1214.

Pump Rental Preference: In the event that I should require a pump for enteral feeding, I choose to do the following after the initial 10-month rental period:

____ Rent the Pump ____ Purchase the Pump _____Not Applicable Due to Medical Wishes

Client/Patient Signature:_____ Date: _____

Witness:_____ Date: _____

COMPLETE THIS SECTION IF SIGNED BY SOMEONE OTHER THAN THE PATIENT/CLIENT:

Name of Person Signing_____ Relationship to Client/Patient: _____

Signature _____ Date: _____

REASON CLIENT/PATIENT COULD NOT/DID NOT SIGN: _____

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