RENTAL / PURCHASE / AGREEMENT

REQUEST FOR MEDICAL SERVICES ☐

By signing this agreement, I authorize the provision of products and or services from MEDOX Corporation or its affiliates. MEDOX Corporation agrees to make such provisions.

MEDICAL SUPERVISION, RESPONSIBILITY, & HOLD HARMLESS ☐

I am under the care and supervision of my physician. The medical products, supplies or services have been prescribed by my physician who was fully explained the purpose, risks or possible complications of this treatment. I shall hold harmless, save and indemnify MEDOX Corporation, its officers, directors, agents, employees, and their heirs, successors and assigns, from and against any and all causes of action, claims, demands, losses, death of persons, fines, damages, or other expenses (including reasonable attorneys' fees) which may be sustained by the actual or alleged presence, use, or operation of the equipment.

PAYMENT AGREEMENT ☐

I agree that I am responsible for payment for any such products and services. All payments are due upon receipt. All outstanding accounts shall accrue interest at 18% or the highest rate allowed by law. If my account is referred for collection or legal action, I am responsible for collection costs, including court and reasonable attorneys' fees.

ASSIGNMENT AGREEMENT ☐

Should MEDOX Corporation agree to accept my insurance and or Medicare assignment, I request that payment of authorized Medicare, Medicaid or other insurance be made on my behalf directly to MEDOX Corporation for any medical products, supplies or services rendered by MEDOX Corporation. In the event insurance benefit payments are made directly to me, I will endorse all checks for such payments to MEDOX Corporation. Any assignment agreements are on a month to month basis and subject to change any time at the sole discretion of MEDOX Corporation. I understand I am responsible for payment of any denials, non-covered items or services, payment reductions, copayments and deductibles, upon receipt of bill.

OWNERSHIP, TITLE AND REPOSSESSION ☐

Unless expressly specified as a sale, rental products remain the property of MEDOX Corporation. Rental of equipment does not imply any contract to purchase. Title for items of sale does not pass to the purchaser until any and all payment balances are paid. Use of equipment at any location other than the disclosed local address, without permission from MEDOX Corporation, is prohibited. The right to possess rental items terminates with the expiration of the prescription period. Continued possession constitutes a material breach of this contract. Extension of this contract is at the sole discretion of MEDOX Corporation. Except reasonable wear and tear, I am responsible for damage and or loss of the equipment regardless of the cause. Upon payment failure or any other breach of this contract, MEDOX reserves the right to repossess the items without liability for damage claims or trespassing arising out of such removal.

RELEASE OF INFORMATION ☐

I hereby authorize any holder of medical information about me to release to my insurance carrier or any agency or representative of said insurance company for the purpose of obtaining payment for services provided to me. I also authorize the review of my records including medical records by any Federal, state or accrediting body or agency as required by the regulatory, licensing or accrediting body.

TOTAL AGREEMENT AND JURISDICTION ☐

This agreement is the entire agreement between the two parties and supersedes any other discussions or agreements related to the subject of rental or purchase of goods or services. This agreement is covered and construed in accordance with the laws of the State of Florida. I certify that I have read and received a copy of this document. I also certify that I am the patient or am authorized by the patient as an agent to execute the above and accept its terms. I understand that no modifications of this contract will be binding unless they are in writing, duly accepted, and executed by both parties. This agreement begins with acceptance of services and shall continue until the products are returned, all rental payments made and all other obligations fulfilled.

ACHA & Abuse 800-962-2873 • Complaint 888-419-3456

Patients (Patient Agent) Signature

Witness

(See reverse side)

MEDICARE DMEPOS SUPPLIER STANDARDS

The Palmetto web site states:
DMEPOS suppliers have the option to disclose the following statement to satisfy the requirement outlined in Supplier Standard 16 in lieu of providing a copy of the standards to the beneficiary.

Same Paragraph/New Link: effective February 2016

The products and/or services provided to you by MEDOX CORPORATION 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://www.ecfr.gov. Upon request we will furnish you a written copy of the standards.

MEDOX OXYGEN CONCENTRATOR INSTRUCTION CHECKLIST

PLEASE NOTE:

THIS CHECKLIST IS DESIGNED TO INSURE THE PATIENT AND OTHERS INVOLVED UNDERSTAND THE PURPOSE AND OPERATION OF THIS EQUIPMENT. MEDOX DOES NOT MAKE ANY CLAIM CONCERNING THE EFFECTIVENESS OF OXYGEN THERAPY. THE TREATMENT IS DEFINED BY A PHYSICIAN.
SHOULD THE EQUIPMENT NOT OPERATE PROPERLY OR THERE IS A QUESTION ABOUT ITS OPERATION, CALL MEDOX. LIABILITY IS LIMITED TO REPAIR OR REPLACEMENT.

PERSONS RECEIVING INSTRUCTIONS _____

ADDRESS _____ **DATE** _____

CUSTOMER SERVICE TECHNICIAN _____

GENERAL INFORMATION

- ☐ Ensure appropriate persons are present during instructions.
- ☐ Explain the body's need for oxygen.
- ☐ Provide written instructions and advise all present to read them completely.
- ☐ Explain doctor's prescription.
- ☐ Provide patient and others present with MEDOX 24 hour phone number.
- ☐ Explain procedure for ordering supplies and, if applicable, portable oxygen delivery.
- ☐ Advise that no one should attempt to make repairs or adjustments to equipment.

SAFETY PRECAUTIONS AND INFORMATION

- ☐ Explain that oxygen is nonflammable but greatly accelerates combustion.
- ☐ Explain fire hazards associated with oxygen and ignition sources, such as smoking, etc.
- ☐ Explain electrical hazards. don't use lightweight extension cords, don't overload circuits.
- ☐ Explain other warnings stated in operating instructions.
- ☐ Advise that persons who have not read operating instructions are not to operate equipment.
- ☐ Explain the concentrator's alarms and what conditions exist when they sound.

THE OXYGEN CONCENTRATOR

- ☐ Identify and describe the functional parts of the concentrator.
- ☐ Explain how the oxygen concentrator works.
- ☐ Explain importance of airflow through concentrator and keeping at least 6-12" from objects.
- ☐ Explain operating instructions, including adjusting flowmeter for proper flow.
- ☐ Demonstrate setup of cannula, tubing, and humidifier. Explain their purpose, maintenance and frequency of replacement.
- ☐ Explain and demonstrate filter maintenance procedures.
- ☐ Have patient demonstrate the operation of the unit.

I, _____ **HAVE BEEN INSTRUCTED AND UNDERSTAND THIS INFORMATION**

Medicare Capped Rental and Inexpensive or Routinely Purchased Items Notification for Services on or after January 1, 2006

I received instructions and understand that Medicare defines the _____ that I received as being either a capped rental or an inexpensive or routinely purchased item.

____ FOR CAPPED RENTAL ITEMS:

- 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.
- Examples of this type of equipment include:

Hospital beds, wheelchairs, alternating pressure pads, air-fluidized beds, nebulizers, suction pumps, continuous airway pressure (CPAP) devices, patient lifts, and trapeze bars.

____ FOR 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.
- Examples of this type of equipment include:

Canes, walkers, crutches, commode chairs, low pressure and positioning equalization pads, home blood glucose monitors, seat lift mechanisms, pneumatic compressors (lymphedema pumps), bed side rails, and traction equipment.

- I select the:

Purchase Option _____ Rental Option _____

_____ _____

Beneficiary Signature Date

NOTICE OF MINIMAL SUPPLIER STANDARDS

MEDOX Corporation (1) must be in compliance with all applicable Federal and State licensure and regulatory requirements ; (2) 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 must sign the application for billing privileges ; (4) must fill orders from its own inventory, or must contract with other companies for the purchase of items necessary to fill the order. MEDOX may not contract with any entity that is currently excluded from the Medicare program, any State health care program, or from any other Federal procurement or non procurement programs ; (5) 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) 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) must maintain a physical facility on an appropriate site ; (8) must permit CMS, or its agents, to conduct on site inspections to ascertain compliance with these standards. The location must be accessible to beneficiaries during reasonable business hours and must maintain a visible sign and posted hours of operation ; (9) 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 is prohibited ; (10) must have comprehensive liability insurance in the amount of at least $300,000 that covers both the place of business and all customers and employees of MEDOX. If MEDOX manufactures its own items, this insurance must also cover product liability and completed operations ; (11) must agree not to initiate telephone contact with beneficiaries, with a few exceptions allowed. This standard prohibits suppliers from calling beneficiaries in order to solicit new business ; (12) is responsible for deliver and must instruct beneficiaries on use of Medicare covered items and maintain proof of delivery ; (13) must answer questions and respond to complaints of beneficiaries and maintain documentation of such contacts ; (14) must maintain and replace at no charge or repair directly, or through a service contract with another company, Medicare covered items it has rented to beneficiaries ; (15) must accept returns of substandard or unsuitable items from beneficiaries ; (16) must disclose these supplier standards to each beneficiary to whom it supplies a Medicare covered item ; (17) must disclose to the government any person having ownership, financial, or control interests in MEDOX ; (18) must not convey or reassign a supplier number ; (19) 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, an any actions taken to resolve it ; (21) must agree to furnish CMS any information required by the Medicare statute and implementing regulations ; (22) must be accredited by a CMS-approved accreditation organization in order to receive and retain a supplier billing number ; (23) must notify their accreditation organization when a new DMEPOS location is opened ; (24) must meet the DMEPOS quality standards and be separately accredited in order to bill medicare ; (25) must disclose upon enrollment all products and services, including the addition of new product lines for which they are seeking accreditation. If a new product line is added after enrollment, the DMEPOS supplier will be responsible for notifying the accrediting body of the new product so that the DMEPOS supplier can be re-surveyed and accredited.

We at MEDOX Corporation believe that each of our customers/ patients also have a right to:

- Be treated with dignity, courtesy, and respect.
- Receive reasonable coordination and continuity of services from referring agency for healthcare equipment services.
- Receive a timely response from MEDOX Corporation when healthcare equipment is needed or requested.
- Be informed of appropriate policies, procedures, and charges for equipment and services, including eligibility for third party reimbursement to the extent it is available and receive an explanation of all forms that are requested to be signed.
- Receive healthcare equipment and services with intended ethical, moral, and legal use regardless of race, religion, political belief, sex, social status, age or disability.
- Receive proper identification of name and title from personnel providing the services.
- Participate in decisions concerning equipment service needs.
- Have all records (except as otherwise provided for by law or third party payor contracts) And all communications, written or oral, between customers and healthcare providers treated confidentially.
- Access all health records pertaining to the customer and the right to challenge and have the records corrected for accuracy.
- Express dissatisfaction and suggest changes in any service without coercion, discrimination, reprisal, or unreasonable interruption in service.
- Be informed of responsibilities regarding healthcare equipment usage and services.
- Choose service providers and refuse all services for whatever reason any time to the extent permitted by law.

Confidetiality: Our Company is HIPAA compliant and all information concerning your care will be treated confidentially. You will receive on the day of your delivery a copy of our HIPAA policy.

MEDOX CORPORATION

PATIENT PLAN OF CARE

PATIENT NAME _____

☐ Oxygen Concentrator with Portable ☐ Liquid Oxygen System ☐ Aerosol Compressor / Nebulizer	☐ Aerosol Hi-Volume ☐ Suction Unit ☐ IPPB	☐ CPAP ☐ BIPAP ☐ Other _____

Date	Problem / Needs of the Patient	Patient Goals	Organization's Action	Initials
_____	**PROBLEM / DIAGNOSIS** _____ _____ _____	**PATIENT WILL BE ABLE TO SAFELY USE AND OPERATE HIS/HER EQUIPMENT AS OUTLINED IN COMPANY POLICIES AND PROCEDURES FOR EQUIPMENT MARKED ABOVE.**	**PATIENT WILL RECEIVE EQUIPMENT AND INSTRUCTIONS PER COMPANY POLICY AND PROCEDURES FOR EQUIPMENT MARKED ABOVE.** **EQUIPMENT WILL BE MAINTAINED ACCORDING TO COMPANY POLICIES AND PROCEDURES.**	_____ _____
_____	**NEEDS:** _____ _____ _____	**PATIENT WILL FOLLOW THE DESIGNATED PLAN OF CARE BASED ON SPECIFIC PHYSICIAN DIRECTIONS**	**PATIENT WILL RECEIVE SPECIFIC INSTRUCTIONS AND REASONS FOR THE IMPORTANCE TO COMPLY WITH THE PLAN OF CARE**	_____
_____	**PATIENT PREPAREDNESS AND READINESS FOR A NATURAL DISASTER (i.e. HURRICANE, TORNADO, FLOOD, EVACUATION)** **NOTE: Please, see revere side for the Safety and Environmental needs of the Patient / Client. Any sections affecting this patient must be covered with the patient and properly recorded.**	**PATIENT WILL FOLLOW GUIDELINES AND INSTRUCTIONS SET FORTH BY FEMA AND WILL BE FAMILIAR WITH OUR HURRICANE GUIDE.**	**PATIENT / CLIENT:** **1) WILL RECEIVE A PATIENT HURRICANE GUIDE AND THOSE AREAS THAT AFFECT THEIR PLAN OF CARE WILL BE EXPLAINED. THE HURRICANE PLAN MOSTLY ADDRESSES OXYGEN PATIENTS.** **2) WILL BE ADVISED THAT THE COMPANY HAS FLOOD AREA AND EVACUATION AREA INFORMATION, AS WELL AS EVACUATION ROUTE INFORMATION BY COUNTY.** **3) WILL BE ADVISED THAT THE COMPANY HAS LISTINGS OF ALL RED CROSS CHAPTERS, FEMA OFFICES AND MUCH OTHER PERTINENT INFORMATION TO PLAN AND INSURE THEIR SAFETY BEFORE DURING AND AFTER A MAJOR DISATER.** **4) WILL RECEIVE OUR MOST RECENT ANNUAL HURRICANE PLAN FOR THEIR SAFE KEEPING AND REFERENCE. THE PLAN WILL BE EXPLAINED DURING THE ORIGINAL SET UP.** **5) WILL BE ADVISED THAT THE COMPANY HAS SURVIVAL SUPPLY KIT AND PET KIT LISTINGS TO HELP THEM PREPARE FOR A DISASTER.**	_____ _____ _____ _____

PATIENT SAFETY AND ENVIRONMENTAL ASSESSMENT

DATE	PROBLEMS / NEEDS OF THE PATIENT/CLIENT	PATIENT/CLIENT GOALS	COMPANY SERVICES RESPONSIBILITIES	INITIALS
_____	☐ Cluttered/Dirty or Poor Hygiene	Patient/Client or the Caregiver will use & transport equipment in a safe and effective manner.	Patient/Client will be instructed in the safe use and transportation of the equipment.	_____
_____	☐ No Telephone	Patient/Client will be available for routine maintenance visits	Patient/Client will be advised of the frequency of visits. As per the Company policy, emergency contact numbers are obtained. Patient has access to neighbor phone to contact the Company in an emergency.	_____
_____	☐ No Grounded Electrical Outlets	Patient/Client will understand the importance of grounded electrical outlets	Patient/Client will be instructed to have outlets grounded. If not able, proper notation must be made.	_____
_____	☐ Use of Extension Cords to Power Equipment	Patient/Client will understand the potential hazards associated with the use of extension cords to power equipment.	Patient/Client will be advised of hazard and will assist the Patient/Client in selecting a more adequate electrical outlet.	_____
_____	☐ Power Failures	Patient/Client will understand the use of the back-up equipment (i.e. batteries, 0_2 tanks) used to either power equipment or in lieu of electrically driven units.	Patient/Client will be instructed in the use of all back-up equipment and where applicable, the Power Company will be notified of the patient's special needs.	_____
_____	☐ Equipment Failures	Patient/Client will understand basic troubleshooting techniques and will understand how to contact The Company after hours.	Patient/Client will be provided with reference materials that include troubleshooting guides. The Company will provide a telephone listing on how to contact the company after hours, 24 hours a day.	_____
_____	☐ Patient Safety	Patient / Client will understand the various safety areas when using the equipment.	Patient / Client will be provided with a copy of our Safety Statement and reviewed at the time of delivery.	_____
_____	☐ Patient has a smoke detector, fire extinguisher or just one or the other.	Patient/ Client will understand the safety measures of having a working smoke detector and an ABC fire extinguisher	Patient will be recommended to acquire a smoke detector and a 2½ lbs. ABC fire extinguisher for the home.	_____
_____	☐ There is evidence of smoking, candles, portable electric heaters, matches & exposed flammable materials in the home.	Patient / Client will understand the hazards of open flames or smoking when oxygen is in use. Patient / Client will also understand about the proper storage of oxygen cylinders.	Patient will be reminded of the hazards that a candle, match, cigarette, portable heater, equipment too close to an open pilot or stored in limited spaces. A copy of the Oxygen Statement will be provided for the Patient / Client and reviewed.	_____
_____	☐ Patient was observed in a hospital bed without rails up or wheels locked.	Patient / Client will understand the safety requirements in the use of the bed	Patient / Client will be educated in the use of the rails and locked wheels in the bed foot end to prevent falls from the bed or while boarding or getting off the bed.	_____
_____	☐ Patient was observed not using the brakes on a wheelchair while mounting and dismounting.	Patient / Client will understand the proper technique of getting in and out of a wheelchair.	Patient / Client will be advised of the hazards of not using the brakes to get in and out of the wheelchair	_____

I hereby acknowledge that I have received the following documentation:

- ☐ Welcome package, brochures, business cards
- ☐ Equipment Instructions
- ☐ Safety Statement
- ☐ CMS- Medicare Supplier Standards
- ☐ HIPAA Privacy Act Statement
- ☐ Patient Right's & Responsibilities
- ☐ Protocol for Resolving Complaints
- ☐ Inexpensive and Routinely Purchased Items Notification
- ☐ Equipment Warranty
- ☐ Living Will & Health Care Surrogate information
- ☐ Hurricane Patient Guide and Preparedness Plan
- ☐ Patient/Caregiver understands our hours of operation, emergency procedures, after hours on-calls policy, after hour telephone numbers

_____ _____

Signature of patient or caregiver Date

MEDOX
CORPORATION

"A Message From Management"

Dear Customer,

Medox Corporation is available 24 hours per day, 365 days a year. Our regular operating hours are from 8:00 a.m. through 5:00 p.m. , Monday through Friday. Each day at 5:00 p.m. until 8:00 a.m. the following morning, and throughout each weekend and holiday, our telephone answering service monitors our incoming calls, which are relayed to the personnel on call that evening or weekend/holiday.

Medox Corporation may be reached at 941-923-9461 for services, insurance coverage questions, sales or technical information, scheduling, billing, equipment problems, product information or discontinuation of our service. These numbers are also for communicating any deficiencies, complaints or incidents you feel need to be conveyed to us. Please, remember that although we close on all legal holidays, we will still have personnel on duty to respond to your situation.

Medox Corporation together with your physician has carefully selected the equipment you have received. We ask that you carefully and thoroughly read the **"Assignment of Benefits"**, our **"Patient Rights and Responsibilities"** and our **HIPPA Privacy Practices Notice** that our representative discussed with you and left there for your records.

Medox Corporation rents and sells the equipment you will be using. Most Insurance Carriers. Medicare and Medicaid have approved certain categories of equipment they will buy outright and other equipment will rent until the rental caps. This equipment then passes title to you. Some types of equipment will rent for a maximum of thirteen (13) months and others for a maximum of 36 months. **We would be happy to discuss your options, should you need more information, after the equipment caps. You may call us at 941-923-3461 to speak with our Insurance/Accounting Department, who will be happy to review with you the financial responsibilities.**

It is important that our care to you, our customer, be characterized by a caring, professional attitude combined with a sense of pride and the greatest degree of excellent service from all of Medox Corporation representatives involved in your care. **Should you wish to discuss any issue(s) with me, do not hesitate to contact me at any of the numbers mentioned above.**

We are a Medicare Provider and as such, we must meet and provide you with their 25 Provider Standards. We comply with all of these Standards and further, **we are presently going through a National Accreditation Process to insure that you, our staff and our community know that we are committed to providing the best possible Quality of Patient Care available in the home environment.**

Thank You for using Medox Corporation for your medical equipment needs.

Sincerely Yours,

T.L. Shaeffer
President

MEDOX
CORPORATION

PRIVACY PRACTICES ACKNOWLEDGMENT

DELIVERY ACKNOWLEDGMENT FORM

ENGLISH

I have received the Notice of Privacy Practices from the Company and I have been provided an opportunity to read and think about the content of this authorization form and I agree with all statements made in this authorization. I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of the protected health information for purposes of providing for my health care.

Please, return this form with the information below in the enclosed pre-addressed pre-stamped envelope for our files ASAP.

ESPAÑOL

Yo he recibido el Aviso Sobre Las Práctic[illegible] de la Firma y me han dado la oportunidad de leer y pensar sobre el contenido de esta [illegible]erdo con todas las declaraciones expuestas en éste formulario de autoriza[illegible] firmar ésta autorización, yo estoy autorizando para uso y para divulgar inf[illegible] salud con el objeto de proveer el cuidado de mi salud.

Please Sign + Return Enclose Envelope

Le agradecemos la devolución de esta [illegible]le abajo, en el sobre incluido con remitente y sello postal.

Name _____ Birth Date _____
Nombre Fecha de Nacimiento

Signature _____ Date _____
Firma Fecha

Thank You,

Records Keeper

MEDOX CORPORATION

PATIENT SATISFACTION SURVEY

PLEASE RATE OUR SERVICES
HOW ARE WE DOING?

EXCELLENT	GOOD	AVERAGE	FAIR	POOR	N/A	
○	○	○	○	○	○	**Was the equipment and/or supplies promptly delivered?**
○	○	○	○	○	○	**Are you aware of the hazards of smoking & open flames while oxygen is present?**
○	○	○	○	○	○	**Do you feel the equipment prescribed is helping you and that it meets your health care needs?**
○	○	○	○	○	○	**Did the Service Technician discuss with you Supplies Replacement and Disinfection procedures? (i.e. cannulas, extension tubing, humidifiers, nebulizer circuits, etc.)**
○				○	○	**Does the equipment operate properly?**
○				○	○	**Where adequate instructions provided for the safe use of the equipment?**
○				○	○	**Was the staff courteous and helpful?**
○				○	○	**Do you know how to contact us after hours, weekends and holidays?**
○	○	○	○	○	○	**Do you have a family hurricane preparedness plan?**
○	○	○	○	○	○	**Overall, the services I received were to my satisfaction**
○	○	○	○	○	○	**I would recommend your services to my friends & family**

Please Sign AND Return

PATIENT NAME (OPTIONAL)_____

THANK YOU FOR USING OUR SERVICES

PROTOCOL FOR RESOLVING COMPLAINTS FROM MEDICARE BENEFICIARIES

The patient has the right to freely voice grievances and recommend changes in care or services without fear of reprisal or unreasonable interruption of services. Service, equipment, and billing complaints will be communicated to management and upper management. These complaints will be documented in the *Medicare Beneficiaries Complaint Log*, and completed forms will include the patient's name, address, telephone number, and health insurance claim number, a summary of the complaint, the date it was received, the name of the person receiving the complaint, and a summary of actions taken to resolve the complaint.

All complaints will be handled in a professional manner. All logged complaints will be investigated, acted upon, and responded to in writing or by telephone by a manager within a reasonable amount of time after the receipt of the complaint. If there is no satisfactory resolution of the complaint, the next level of management will be notified progressively and up to the president or owner of the company.

The patient will be informed of this complaint resolution protocol at the time of set-up of service.

MEDOX
CORPORATION

NOTICE OF PROTECTED HEALTH INFORMATION

This notice describes how health information about you may be used and disclosed and how you can get access to your identifiable health information. This process is as required by the Privacy Regulations Promulgated Pursuant to the Health Insurance Portability Act of 1996 or otherwise known as HIPPA.

PLEASE REVIEW THIS NOTICE CAREFULLY

A. OUR COMMITMENT TO YOUR PRIVACY

Our organization is dedicated to maintaining the privacy of your identifiable health information. In conducting our business, we will create records regarding you and the treatment and services we provide you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and privacy practices concerning your identifiable health information. By law, we must follow the terms of the notice of privacy practices that we have in effect at the time. To summarize, this notice provides you with the following important information:

* How we may use and disclose your identifiable health information.
* Your privacy rights in your identifiable health information.
* Our obligations concerning the use and disclosure of your identifiable health information.

The terms of this notice apply to all records containing your identifiable health information that are created or retained in our practice. We reserve the right to revise or amend our notice of privacy practices. Any revision or amendment to this office will be effective for all your records our practice has created or maintained in the past, and for any of your records we may create or maintain in the future. Our organization will post a copy of our current notice in our offices in a prominent location, and you may request a copy of our most current notice during any office visit.

B. IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Dot Hicks Attn: Patient Records Keeper at (941) 923-3461

C. WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION IN THE FOLLOWING WAYS:

The following categories describe the different ways in which we may use and disclose your identifiable health information:

1. Treatment. Our organization may use your identifiable health information to treat you. For example, we may ask you to undergo laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. Many of the people who work for our organization may use or disclose your identifiable health information in order to treat you or to assist others in your treatment. Additionally, we may disclose your identifiable health information to others who may assist in your care, such as your physician, therapists, spouse, children or parents.

2. Payment. Our organization may use and disclose your identifiable health information in order to bill and collect payment for services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your identifiable health information to obtain payment from third parties who may be responsible for such costs, such as family members. Also, we may use your identifiable health information to bill directly for services or items.

3. Health Care Operations. Our organization may use and disclose your identifiable health information to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our organization may use and disclose your information to our operations; our organization may use your health information to evaluate the quality of care you received from us or to conduct cost-management and business planning activities for our practice.

OPTIONAL:
4. Appointment Reminders. Our organization may use and disclose your identifiable health information to contact you and remind you of visits/deliveries.

OPTIONAL:
5. Health Related Benefits and Services. Our organization may use and disclose your identifiable health information to inform you of health-related benefits or services that may be of interest to you.

OPTIONAL:
6. Release of Information to Family/Friends. Our organization may use and disclose your identifiable health information to a friend or family member whom is helping you pay for your health care or who assists in taking care of you.

7. Disclosures Required By Law. Our organization may use and disclose your identifiable health information when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR IDENTIFIABLE HEALTH INFORMATION IN CERTAIN SPECIAL CIRCUMSTANCES.
The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

- Maintaining vital records, such as birth and deaths
- Reporting child abuse or neglect
- Preventing or controlling disease, injury, disability
- Notifying a person regarding potential exposure to a communicable disease
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition.
- Reporting reactions to drugs or problems with products or devices
- Notifying individuals if a product or device they may have been using has been recalled
- Notifying appropriate government agency (ies) and authority (ies) regarding the potential abuse or neglect of an adult patient (including domestic violence; however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information.
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health Oversight Activities. Our organization may use and disclose your identifiable health information to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our organization may use and disclose your identifiable health information in response to a courted or administrative order if you are involved in a lawsuit or similar proceeding. We may also disclose your identifiable health information in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

MEDOX
CORPORATION

PATIENT CONSENT FORM

The purpose of this consent form is to inform you, the patient, how your personal health information is used and/or disclosed by this provider or organization. We want you to be fully aware of what we do with your information so that you can provide us with your consent in order for us to treat your health care needs, receive payment for services rendered, and allow administrative and other types of health care operations to happen, which are part of normal business activities of this provider or organization.

Your Consent

I understand that as part of my health care, this organization originates and maintains health records describing my health history, symptoms, test results, diagnosis, treatment, and plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health care professionals who contribute to my care
- A source of information for applying my diagnosis/es and other health information to my bill(s)
- A means by which my health plan or health insurance can verify that services billed were actually provided
- A tool for routine health care operations in this organization, such as ensuring that we have quality processes and programs in place and making sure that the professionals who provide your care are competent to do so.

I understand that:

- I have been provided with a Notice of Information Practices that provides specific examples and descriptions of how my personal health information is used and disclosed by THE Provider of Medical equipment (Attached).
- I have the right to review the Notice of Information Practices prior to signing this consent;
- The Provider of Medical Equipment can change its Notice of Protected Health Information Privacy Practices but must notify me of those changes before they are put into practice and will mail me a copy of the new Notice to the address that I have provided.
- I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations and that Provider of Medical Equipment is not required to agree to those restrictions;
- Any restrictions to which Provider of Medical equipment agrees to will be respected;
- I may revoke this consent in writing at any time. Further, I am aware that the Provider of Medical Equipment. can proceed with uses and disclosures that pertain to treatment, payment, or healthcare issues that took place before the consent was revoked.

To request a restriction on the use and disclose of your personal health information related to your treatment, payment for service, or for the health care operations of The Medical Provider of Equipment. please do so after reading the Notice of Protected Health Information Privacy Practices. You may use this consent form to request a restriction.

I request the following restrictions to the use or disclosure of my health information: _____

_____

Please provide your signature below to indicate that you have read the above consent and have reviewed the Notice of Protected Health Information Privacy Practices.

Signature of Patient or Legal Representative	Witness	Date Signed	Effective Date
_____	_____	_____	_____

For Provider Use Only:

O Restriction is accepted O Restriction is denied
Reason denied: _____

O Patient Notified
Date Notified _____

4. Law Enforcement. We may release identifiable health information if asked to do so by law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement.
- Concerning a death we believe might have resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator.

5. Serious Threats to Health or Safety. Our organization may use and disclose your identifiable health information when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

6. Military. Our organization may use and disclose your identifiable health information if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate military command authorities.

7. National Security. Our organization may use and disclose your identifiable health information to federal officials for intelligence and national security activities by law. We also disclose your identifiable health information to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

8. Inmates. Our organization may use and disclose your identifiable health information to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: a) for the institution to provide health care services to you; b) for the safety and security of the institution; and/or e) to protect your health and safety or the health and safety of other individuals.

9. Worker's Compensation. Our organization may use and disclose your identifiable health information for worker's compensation and similar programs.

E. <u>YOUR RIGHTS REGARDING YOUR IDENTIFIABLE HEALTH INFORMATION</u>

You have the following rights regarding the identifiable health information that we maintain about you:

1. **Confidential Communications.** You have the right to request that our organization communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential information, you must make a written request to DOT HICKS Patient Records Keeper at MEDOT CORPORATION, specifying the request method of contact or the location where you wish to be contacted. Our organization will accommodate **reasonable** requests. You do not need to give a reason for your request.
2. **Requesting Restrictions.** You have the right to request a restriction in our use or disclosure of your identifiable health information for treatment, payment, or health care operations. Additionally, you have the right to request that we limit our disclosure of your identifiable health information to individuals involved in your care or the payment of your care, such as family members and friends. **We are not required to agree with your request;** however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your identifiable health information, you must make your request in writing to DOT HICKS. Patient Records Keeper at MEDOT CORPORATION Your request must describe in a clear and concise

fashion: (a) the information you wish restricted; (b) whether you are requesting to limit our practice's use, disclosure, or both; and (c) to whom you want the limits to apply.

3. **Inspections and Copies.** You have the right to inspect and obtain a copy of the identifiable health information that may be used to make decisions about you, including medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to DOT HICKS Patient Records Keeper at MEDOX CORPORATION in order to inspect and/or obtain a copy of your identifiable health information. **Our organization may charge a fee for the costs of copying, mailing, labor and supplies associated with your request.** Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of your denial. Another licensed health care provider chosen by us will conduct reviews.
4. **Amendment.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our organization. To request an amendment, your request must be made in writing and submitted to DOT HICKS Patient Records Keeper at MEDOX CORPORATION, you must provide us with a reason that supports your request for amendment. Our organization will deny your request if you fail to provide us with this information. Also, we may deny your request if you ask us to amend information that is: (a) accurate and complete; (b) not part of the identifiable health information kept by or for the organization; (c) not part of the identifiable health information which you would be permitted to inspect and copy; or (d) not created by our organization, unless the individual entity that created the information is not available to amend the information
5. **Accounting of Disclosures.** All of our patients have the right to request an "accounting of disclosures." An: accounting of disclosures" is a list of certain disclosures our organization has made of you identifiable health information. In order to obtain an accounting of disclosures, you must submit your request in writing to DOT HICKS Patient Records Keeper at MEDOX CORPORATION. All requests for an " accounting of disclosures" must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, **but our practice may charge you for additional lists within the same 12-month period.** Our organization will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.
6. **Right to a Paper Copy of This Notice.** You are entitled to receive a paper copy of our notice of Privacy Practices. You may ask us to give you a copy of this notice any time. To obtain a paper copy of this notice, contact DOT HICKS, Patient Records Keeper at MEDOX CORPORATION
7. **Right to File a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with our organization or with the Secretary of the Department of Health and Human Services. To file a complaint with our organization, contact DOT HICKS, General Manager at MEDOX CORPORATION. All complaints must be filed in writing. **You will not be penalized for filing a complaint.**
8. **Right to Provide an Authorization for Other Uses and Disclosures.** Our organization will obtain your written authorization for uses and disclosures that are not identified by this notice permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your identifiable health information may be revoked at any time **in writing**. After you revoke your authorization, we will no longer use or disclose your identifiable health information for the reasons described in the authorization. Please note, we are required to retain records of your care.

Sincerely Yours,

MEGAN E. SHAEFFER

President, CEO

MEDICAL OXYGEN IN USE

NO SMOKING

No Open Flame

MEDOX Corporation Medical Oxygen &
Healthcare Equipment Services