Instructions

The following materials are presented for you to use as the required materials you provide to your customers. These items meet both accreditation and CMS requirements. If you presently use paperwork that meets these requirements, you do not need to change your process to include this packet.

If you do choose to use this packet, you will need to replace your company name in every place that MEDOX Corporation appears as well as customize all additional yellow highlighted areas.

You can print this packet back-to-back for all pages that stay with the patient, but for all that are signed by the patient, do not print back-to-back. In the lower left corner of each form, you will find instructions as to which forms should be left with the patient for informational purposes and which forms need to be signed by the patient and retained in the patient record.

On those forms that show “This form is kept in the Patient Record”, you should either have your printer print the form in two-parts or include two copies of the form so that one can be kept with the patient and the signed copy be filed in the patient chart.

You will notice that ABN (*when applicable*) is included on the packet checklist. There are situations when you will need to get an ABN (Advance Beneficiary Notice) signed for Medicare purposes. You can not use a multiple-version copy of the ABN, you are required to use a clean page (or a copy of the form itself obtained from Medicare), thus it is not included in the packet.

To download the current ABN form, go to the CMS website at: www.cms.gov and download form number R-131.

If you are using the entire packet, delete this page of instructions when you are finished customizing the document and have saved your updated version. The pages will then be numbered appropriately to match the front page of the packet.

MEDOX CORPORATION

Hours of Operation

Monday through Friday 8:00 am – 5:00pm

ON-CALL SERVICES AVAILABLE AFTER BUSINESS HOURS

4233 Clark Road – Suite 20 – Sarasota, Fl 34233
Phone: 941-923-3461
E-mail: info@medoxcorp.com

PATIENT INFORMATION PACKET

Table of Contents

This page remains with the patient

WELCOME

*About MEDOX is actually all about **YOU**!*

We celebrate more than 30 years of continued service and have developed invaluable working relations. MEDOX Corporation has earned and maintains a high level of trust, not just from patients and physicians, but also the payers and support personnel who credit the true value MEDOX delivers.

Achieving unsurpassed standards of excellence, technical know-how, and our staff's dedication to integrity as well as genuine concern, we appreciate the continued growth of our respiratory and healthcare equipment services throughout Florida's west coast.

Ask us a question and we will respond with: Yes We Cannula!

--The MEDOX Family

Service is our middle name.

We have many programs to accommodate your healthcare needs. With a simple phone call, we can customize a service program to fit your needs. Call us now: ***1-877-633-6962***.

Some of the services most commonly requested by our customers include:

- Rental and sales of healthcare equipment and supplies
- Medical gasses sales and refills
- Change out services for respiratory disposables
- Concentrator maintenance, service and repairs
- Management of medical equipment
- Biomedical testing and electrical safety equipment inspections
- 24/7 request for service response
- Bed maintenance
- Phone support
- Safe and secure storage of medical equipment
- Respiratory therapy evaluations
- Staff In-Services and patient education programs

MEDOX *is* Accredited.

***What* you need, *where* you need it, *when* you want it!**

If it is *medical* in nature, MEDOX has what you *need*!

MOST ITEMS ARE AVAILABLE FOR PURCHASE OR RENTAL

SAMPLE LIST OF STOCKED ITEMS:

- ALTERNATING PRESSURE PADS
- BLOOD PRESSURE CUFFS
- CANNULAS
- CPAPS
- BILEVELS
- CPM MACHINES
- LIQUID OXYGEN SYSTEMS
- NEBULIZER COMPRESSORS
- MASKS
- OXYEARS
- OXYGEN ANALYZERS
- OXYGEN CONSERVERS
- PERCUSSORS
- PHYSICAL THERAPY EQUIPMENT
- OXIMETERS
- SUCTION PUMPS
- TRACH SUPPLIES
- TRAPEZE BARS
- TRAVEL CONCENTRATORS
- ULTRASONIC NEBULIZERS
- WHEELCHAIRS
- WALKERS/CRUTCHES

DON'T SEE WHAT YOU NEED? CALL US!! 1-877-633-6962

RIGHTS AND RESPONSIBILITIES

As our customer, you are hereby provided this Bill of Rights. You have the right to be notified in writing of your rights and obligations before treatment has begun. The patient's family or guardian may exercise the patient's rights when the patient has been judged incompetent. We fulfill our obligation to protect and promote the rights of our patients, including the following:

Customer Rights

As the patient/caregiver, you have the RIGHT to:

- Be treated with dignity and respect.
- Confidentiality of patient records and information pertaining to a patient's care
- Be presented with information at admission in order to participate in and make decisions concerning your plan of care and treatment.
- Be notified in advance of the types of care, frequency of care, and the clinical specialty providing care and be notified in advance of any change in your plan of care and treatment.
- Be provided equipment and service in a timely manner.
- Receive an itemized explanation of charges.
- Express grievance without fear of reprisal or discrimination.
- Receive respect for the treatment of one's property.
- Be informed of potential reimbursement for services under Medicare, Medicaid or other third-party insurers based on the patient's condition and insurance eligibility (to the best of the company's knowledge).
- Be notified of potential financial responsibility for products or services not fully reimbursed by Medicare, Medicaid or other third-party insurers (to the best of the company's knowledge).
- Be notified within 30 working days of any changes in charges for which you may be liable.
- Be admitted for service only if the company can provide safe, professional care at the scope and level of intensity needed; if we are unable to provide services then we will provide alternative resources.
- Purchase inexpensive or routinely purchased durable medical equipment.
- Expect that we will honor the manufacturer's warranty for equipment purchased from us.
- Receive essential information in a language or method of communication that you understand.
- Each patient has a right to have his or her cultural, psychosocial, spiritual, and personal values, beliefs and preferences respected.
- To be free from mental, physical, sexual, and verbal abuse, neglect and exploitation.
- Access, request an amendment to, and receive an accounting of disclosures regarding your health information as permitted under applicable law.

Customer Responsibilities

As the patient/caregiver, you are RESPONSIBLE for;

- Notifying the company of change of address, phone number, or insurance status.
- Notifying the company when service or equipment is no longer needed.
- Notifying the company in a timely manner if extra equipment or services will be needed.
- Participating as in the plan of care/treatment.
- Notifying the company of any change in condition, physician orders, or physician.
- Notifying the company of an incident involving equipment.
- Meeting the financial obligations of your health care as promptly as possible.

- Providing accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters pertinent to your health.
- Your actions if you do not follow the plan of care/treatment.

Our Rights

As your provider of choice, we have the right to:

- Terminate services to anyone who knowingly furnishes incorrect information to our company to secure durable medical equipment.
- To refuse services to anyone who during direct care is threatening, intoxicated by alcohol, drugs and/or chemical substances and could potentially endanger our staff and patients.

This page remains with the patient

COMPLAINT PROCEDURE

MEDOX Corporation provides a process for clients to lodge an oral, written, or telephone complaint about the products and services provided. MEDOX Corporation has a complaint resolution system for identifying, responding to, and resolving complaints in a timely manner. All written, oral, and Name of client or caregiver voicing the complaint
A summary of the complaint, including:

- Date received
- Name of the person receiving the complaint
- A summary of actions taken to resolve the complaint
- If an investigation is not conducted, the name of the person who made that decision, along with the reason for not conducting an investigation
- Signature of supervisor

All employees are trained in how to handle complaints. Copies of all complaints and investigations are kept on-file for at least three years. All complaints are summarized and presented to Executive Management quarterly.
If you have a complaint, please contact us at 941-923-3461.

Additionally, you may contact Centers for Medicare and Medicaid Services (CMS) at 1(800) MEDICAR, if needed. AHCA'S information center's toll- free number is 1-888-419-3456.

To report abuse, neglect, or exploitation, please call toll-free 1-800-962-2873

You may also contact our accreditation provider if needed. Our accreditation provider is HQAA and can be reached at 1-866-909-4722.
Medicaid fraud means an intentional deception or misrepresentation made by a health care provider with the knowledge that the deception could result in some unauthorized benefit to him or herself or some other person. It includes any act that constitutes fraud under federal or state law related to Medicaid. To report suspected Medicaid Fraud, please call the Attorney General toll-free at 1-866-966-7226. Find out if you are eligible for a reward. Callers may request to remain anonymous

EMERGENCY PREPAREDNESS

MEDOX Corporation has a comprehensive emergency preparedness plan in case a disaster occurs. Disasters may include fire to our facility, chemical spills in the community, hurricanes, tornadoes and community evacuations. Our primary goal is to continue to service your health care needs. It is your responsibility to contact us regarding any supplies you may require when there is a threat of disaster or inclement weather so that you have enough supplies to sustain you.

If a disaster occurs, follow instructions from the civil authorities in your area. We will utilize every resource available to continue to service you. However, there may be circumstances where we cannot meet your needs due to the scope of the disaster. In that case, you must utilize the resources of you local rescue or medical facility. We will work closely with authorities to ensure your safety.

HOME SAFETY INFORMATION

Here are some helpful guidelines to help you keep a careful eye on your home and maintain safe habits. Correct unsafe conditions before they cause an accident. Take responsibility and keep your home safe.

Medicines

	If children are in the home, store medications and poisons in childproof containers and out of reach.
	All medicines should be labeled clearly and left in original containers.
	Do not give or take medicines that were prescribed for other people.
	When taking or giving medicines, read the label and measure doses carefully. Know the side effects of the medicines you are taking.
	Throw away outdate medicines by pouring down a sink or flushing down the toilet.

Mobility items

When using mobility items to get around such as; canes, walkers, wheelchairs, or crutches you should use extra care to prevent slips and falls.

	Use extreme care to avoid using walkers, canes, or crutches on slippery or wet surfaces.
	Always put the wheelchairs or seated walkers in the lock position when standing up or before sitting down.
	Wear shoes when using these items and try to avoid obstacles in your path and soft and uneven surfaces.

Slips and Falls

Slip and falls are the most common and often the most serious accidents in the home. Here are some things you can do to prevent them in your home.

	Arrange furniture to avoid an obstacle course
	Install handrails on all stairs, showers, bathtubs and toilets.
	Keep stairs clear and well lit.
	Place rubber mats or grids in showers and bath tubs.
	Use bath benches or shower chairs if you have muscle weakness, shortness of breath, or dizziness.
	Wipe up all spilled water, oil, or grease immediately
	Pick-up and keep surprises out from under foot, including electrical cords and throw rugs.
	Keep tubing under your control. Tubing may catch on furniture, doors, knobs, throw rugs, or other items on floor.
	Keep drawers and cabinets closed
	Install good lighting to avoid groping in the dark

Lifting

If it is too big, too heavy, or too awkward to move alone – GET HELP. Here are some things you can do to prevent low back pain or injury.

	Stand close to the load with your feet apart for good balance.
	Bend your knees and “straddle” the load.
	Keep your back as straight as possible while you lift and carry the load.
	Avoid twisting your body when carrying a load.
	Plan ahead – clear your way.

Electrical Accidents

	Watch for early warning signs – e.g. overheating, a burning smell, sparks. Unplug the appliance and get it checked right away. Here are some things you can do to prevent electrical accidents.
	Keep cords and electrical appliances away from water.
	Do not plug cords under rugs, through doorways or near heaters. Check cords for damage before use.
	Extension cords must have a big enough wire for larger appliances.
	If you have a broken plug, outlet, or wire, get it fixed right away.

	Use a ground on 3-wire plugs to prevent shock in case of electrical “fault.”
	Do not overload outlets with too many plugs.
	Use three-prong adapters when necessary.

Smell Gas?

	Open windows and doors.
	Shut off appliance involved. You may be able to refer to the front of your telephone book for instructions regarding turning off the gas to your home.
	Don’t use matches, light candles or turn on electrical switches.
	Don’t use telephone – dialing may create electrical sparks.
	Call the Gas Company from a neighbor’s home.
	If your gas company offers free annual inspections, take advantage of them

.

Fire

	Pre-plan and practice your fire escape. Prepare a plan with at least two ways out of your home. If your fire exit is through a window, make sure it opens easily. If you are in an apartment, know where the exit stairs are located. Do not use the elevator in a fire emergency. You may notify the fire department ahead of time if you have a disability or special needs. Here are some steps to prevent fires:
	Install smoke detectors. They are your best early warning. Test frequently and change the battery every year.
	Throw away old newspapers, magazines and boxes.
	Empty wastebaskets and trashcans regularly.
	When there is oxygen in use, place a “No Smoking” sign in plain view of all persons entering the home and do not permit anyone to smoke near the patient
	Do not allow ashtrays or used matches to be tossed into wastebaskets unless you know they are out. Wet down first or dump into toilet.
	Have your chimney and fireplace checked frequently. Look for and repair cracks and loose mortar. Keep paper, wood, and rugs away from area where sparks could hit them.
	Be careful when using space heaters.
	Follow instructions when using heating pad to avoid serious burns.
	Check your furnace and pipes regularly. If nearby walls or ceilings feel hot, add insulation.
	Keep a fire extinguisher in your home and know how to use it.

If you have a fire or suspect fire

1. Take immediate action per plan – escape is your top priority.
2. Get help on the way – with no delay. CALL 9-1-1.
3. If your fire escape is cut-off, close the door and seal the cracks to hold back smoke. Signal help from the window.

*****IF YOU ARE DEPENDENT ON UTLITIES (gas, phone, electricity), REGISTER AS A HIGH PRIORITY CUSTOMER WITH EACH RIGHT AWAY*****

Customer/Caregiver Signature If Caregiver, Relationship to Patient

Witness Signature Date

Assessment Criteria for Patient/Client

Assessment criteria for bathroom aids

	Can the patient/client sit in the tub at tub level?
	Does the patient/client require help with bathing?
	Are there any special construction features in the patient's/client's bathroom that should be considered?
	Is it difficult to get to the bathroom?
	Is a supportive device required to help the patient/client rise to a standing position?
	Is the patient/client able to perform pivotal transfers, or are side transfers required?
	Are there any space restrictions?
	Is the patient/client able to stand during the bathing process?
	Does the patient/client have any balance problems that would require a backrest?

Assessment criteria for respiratory care

	Does the patient/client have breathing problems that are precipitated by dust, pollen, smoke, or strong odors?
	Has the patient/client used this kind of equipment before?
	Will the patient/client have help or supervision while using the equipment?
	What condition/diagnosis requires the use of the device?
	What are the prescribed pressure and/or flow settings, and the frequency and duration of treatment?
	What is the patient's/client's primary water source?
	Does the patient/client ambulate and/or leave the home? If yes, how far and for how long will a portable system be required?
	Has the patient/client recently had laboratory work that would justify the need for the device?
	Is the patient/client, or the caregiver, strong enough to carry and/or move the device as required and/or to change the cylinders?
	Is the patient's/client's (or the caregiver's) sight adequate to make the required adjustments to the device and/or to administer medications?
	Will the patient/client be able to operate the device safely?
	Is the electrical system in the home adequate to meet the requirements of the device?
	Are grounded outlets available in the room in which the device is to be placed?

Assessment criteria for hospital beds

	Is the patient/client confined to a bed or chair?
	Does the patient/client have decubitus (pressure) ulcers, or is the client/patient susceptible to decubitus ulcers?
	Does the patient/client become confused at night, or sometimes fall out of bed?
	Does the patient/client require frequent position changes?
	Does the patient/client require traction devices and/or side rails?
	Is total care required?
	Would the patient/client require the variable-

	height feature?
	Does the patient/client have difficulty with transfers?
	Does the patient/client need to place his or her feet on the floor while sitting on the edge of the bed to help with ambulation?
	Is it difficult for the patient/client to get in and out of bed?
	Will the patient/client be transferring directly from the bed to a wheelchair?
	Does the patient/client have difficulty ambulating?
	Does the patient/client require immediate position changes because of pain and/or impaired breathing?
	Is the patient/client able to operate the controls that raise and lower the bed?
	Will an over-the-bed table be required?
	Is there a physician's order for the device?
	For what condition is the bed required?

Assessment criteria for traction equipment

	For what condition will the traction device be used?
	Is there a physician's order for the device?
	What weights have been prescribed?
	What type of traction device is required?
	Does the patient/client have a hospital bed?
	Has the patient/client previously used a traction device?

Assessment criteria for ambulatory aids

	What type of aid is required?
	For what condition is the aid required?
	What is the patient's/client's height? Weight?
	Does the patient/client have adequate strength to manage the device?
	Is the patient/client able to support weight on at least one extremity?
	Is the patient/client strong enough in the upper torso to support his/her body weight?
	Is lifting or gripping with either hand a serious problem?
	Has the patient/client previously used a walking device?
	Does the patient/client need the extra stability of a four-pronged base?
	Will stair climbing be required?
	Does the patient/client require support on one or both sides?
	Has the patient/client been instructed on the use of the aid?
	Does the patient/client tire easily?
	Is space a consideration when traveling or storing the device?

Assessment criteria for wheelchairs

	For what diagnosis/condition is the chair required?
	Is there a physician's order for the chair?
	Will the patient/client have help in moving the chair?
	Will the patient/client be sitting in the chair for long periods of time?
	Is leg support needed?
	Is the patient/client able to sit upright?
	What is the patient's/client's height? Weight?
	Will the chair need to be equipped with removable arms for side-to-side transfers?

	Does the home have narrow halls/doorways?
	Is the client/patient able to propel the chair by using a hand drive?
	Can the patient/client perform pivotal transfers?
	Does the patient/client have a condition that requires elevation of the lower extremities?
	Does the patient/client need to change position frequently?
	Is sliding out of the chair a problem?
	Does the patient/client have difficulty gripping the hand rim?
	Is additional trunk or head support required?
	Is backward tipping a problem because of weight imbalance?

Customer/Caregiver Signature	If Caregiver, Relationship to Patient
Witness Signature	Date

Assessment Criteria for the Home

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.
	Be careful with smoking materials.
	Never use oxygen in the presence of smoking materials or open flames.

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

	Phone with lit 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.

Customer/Caregiver Signature	If Caregiver, Relationship to Patient
Witness Signature	Date

Plan of Care/Service

	The needs of the patient/client and his/her caregiver are considered when instructing equipment and supplies.
	The treating physician and health care team are consulted to obtain health-related information about the patient/client that could potentially affect the use of the prescribed equipment.
	All communication is documented in a standardized manner within the client medical record.

The plan of care/service can include the following items (as applicable):

	The order or prescription for the item/device/service
	A statement of patient/client problem and/or needs
	Goals or outcomes of care or service, including specific measurable statements
	Actions taken to meet the goals, including:
	initial setup and instruction
	follow-up frequency
	method of ensuring adequate supplies
	specific type, frequency, and duration of visits and/or treatments as well as personnel required
	Description of changes in the patient'/client's needs or conditions
	Identified needs or problems associated with the patient's/client's family support system as they relate to the care or services provided

Customer/Caregiver Signature	If Caregiver, Relationship to Patient
Witness Signature	Date

PATIENT PRIVACY INFORMATION

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

MEDOX Corporation is committed to preserving the privacy of your personal health information. In fact, we are required by law to protect the privacy of your medical information and to provide you with this notice describing the following how your medical information is used and disclosed for your treatment, to obtain payment for treatment, administrative purposes and to evaluate the quality of care that you receive.

Uses and Disclosures: We use and disclose elements of your Protected Health Information (PHI) in the following ways:

- Treatment: including, but not limited to, inpatient, outpatient or psychiatric care.
- To your treating physician(s).
- Payment: including, but not limited to, asking you about your health care plan(s), or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts, either ourselves or through a collection agency or attorney.
- Health care operations: including, but not limited to, financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.
- Disclosures when release is authorized by law: including, but not limited to, judicial settings and to health oversight regulatory agencies, law enforcement and correctional institutions.
- Uses or disclosures for specialized government functions: including, but not limited to, the protection of the President or high-ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign services.
- In emergency situations or to avert serious health / safety situations.
- If you are a member of the armed forces, we may release medical information about you and your dependents as requested by military command authorities.
- Disclosures of de-identified information.
- Disclosures relating to worker's compensation claims.
- To medical examiners, coroners or funeral directors to aid in identifying you or to help them in performing their duties.
- To organizations that handle organ and tissue donations.
- To public health organizations or federal organizations in the event of a communicable disease or to report a defective device or untoward event to a biological product (food or medication).
- Disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information.
- We may be required or permitted by certain laws to use and disclose your medical information for other purposes without your consent or authorization
- We will notify you by e-mail or US Mail of any breaches of your PHI

You have the following rights concerning your protected health information (PHI):

Restrictions: To request restricted access to all or part of your PHI. To do this, contact the organization's HIPAA Privacy and Security Officer. We are not required to grant your request and you do not have the right to restrict disclosures required by law. If we do agree, we must honor the restrictions you request.

Confidential Communications: To receive correspondence of confidential information by alternate means or location such as phoning you at work rather than at home or mailing your health information to a different address. To do this, contact the organization's HIPAA Privacy and Security Officer. We will take reasonable actions to accommodate your request.

Access: To inspect or receive copies of your PHI. To do this, contact the organization's HIPAA Privacy and Security Officer. In certain circumstances you may not have the right to access your records if the organization reasonably believes (or has reason to believe) that such access would cause harm.

Examples include, but are not limited to, certain psychotherapy notes, information compiled in reasonable anticipation of or for use in civil, criminal or administrative actions or proceedings, or information obtained from someone other than a healthcare provider under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information.

Amendments / Corrections: To request changes be made to your PHI. To do this, contact the organization's HIPAA Privacy and Security Officer. We are not required to grant your request if we did not create the record or the record is accurate and complete. If we deny your request for amendment / correction, we will notify you why, how you can attach a statement of disagreement to your records (which we may rebut), and how you can complain. If we agree to the request, we will make the correction within 60 days and will send the corrected information to persons we know who got the wrong information, and others you specify.

Accounting: To receive an accounting of the disclosures by us of your PHI. To do this, contact the organization's HIPAA Privacy and Security Officer. By law, the list will not include disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law, we can have one 30-day extension of time if we notify you of the extension in writing. We are not required to give you a list of disclosures that occurred before April 14, 2003.

This Notice: To get updates or reissue of this notice, at your request.

Complaints: To complain to us or the U.S. Department of Health & Human Services if you feel your privacy rights have been violated. To register a complaint with us, contact: __MEDOX 941-923-3461__. The law forbids us from taking retaliatory action against you if you complain.

Our Duties: We are required by law to maintain the privacy of your protected health information (PHI). We must abide by the terms of this notice or any update of this notice.

As a patient of MEDOX Corporation, you have important rights relating to inspecting and copying your medical information that we maintain, amending or correcting the information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

EQUIPMENT WARRANTY INFORMATION

MEDOX Corporation will honor all manufacturers' warranties under applicable state law. In addition, the manufacturers' manual will be provided to all Rental beneficiaries for all durable medical equipment provided.

If any item delivered to a Rental beneficiary is substandard or unsuitable, MEDOX Corporation will accept the return of the item or exchange the item. You will NOT be responsible for payment for repair or service for your oxygen equipment supplied by MEDOX Corporation.

ASSIGNMENT OF BENEFITS

I request that payment of authorized Medicare benefits be made to me or on my behalf to MEDOX Corporation for durable medical equipment and supplies ordered by my physician. I authorize any holder of medical information about me to release to the Center for Medicare Medicaid Services and its agency any information needed to determine these benefits or the benefits payable for related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If 'other insurance' is indicated in item 9 of the CMS-1500 claim form, or elsewhere on the approved claim form or electronically submitted claims, my signature authorizes releasing the information to the insurer or agency listed. In Medicare assigned cases, the supplier agrees to accept the charge of determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered items. Coinsurance and the deductible are based upon the charge determination to the Medicare carrier.

PROVIDING CORRECT INFORMATION AND INFORMATION RELEASE

I certify that the information I furnish is true and correct. I know it is a crime to fill out this form with facts that I know are false or to leave out facts that are important. I hereby authorize **MEDOX Corporation** to submit a claim to my insurance carrier or its intermediaries for all covered prescriptions or durable medical equipment and authorize and direct my insurance carrier or its intermediaries to issue payment directly to **MEDOX Corporation**. I hereby authorize **MEDOX Corporation** to furnish complete information requested by my insurance carrier or its intermediaries regarding services rendered. I further agree that I am responsible for paying my co-pays or balances which remain after insurance payments have been made, including any cost of collection or legal fee incurred to collect these balances.

Client Signature or Signature of Caregiver	If Caregiver, Relationship to Patient
Witness Signature	Date

This form kept in Patient Record

EQUIPMENT/ SUPPLIES PROVIDED

Qty.	Description/HCPC	Serial/Lot/Model No.	Amount/Charge	Co-pay Amount
1				
2				
3				
		Total Amount Due:		*

* ***Pending Insurance Verification***

I certify that I have received all of the equipment and supplies listed above in excellent condition. I have been properly instructed on how to use and properly take care of the equipment and supplies. I also understand that in the event that payment of my co-insurance or deductible amounts are not made by my insurance carrier(s), I will be responsible for reimbursing to MEDOX Corporation any balance owed up to the allowed amount.

I authorize any employee of MEDOX Corporation to contact me by telephone regarding the equipment and supplies I have received, additional items or supplies that I may need and to discuss any billing and/or accounts receivable information.

Customer/Caregiver Signature If Caregiver, Relationship to Patient

Witness Signature Date

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**

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)

Inexpensive or Routinely Purchased Item (To be Used When an Item is Purchased)

Patient Name: _____
PLEASE PRINT

Item purchased: _____
PLEASE PRINT

I have received verbal and written instructions on how to use the durable medical equipment that I have purchased from **MEDOX Corporation**. I have also been informed of the warranty that this equipment provides to the purchaser. I understand that Medicare defines the item I have purchased as an inexpensive or routinely purchased item.

_____ _____

Customer/Caregiver Signature to Patient | If Caregiver, Relationship

_____ _____

Witness Signature | Date

This form kept in Patient Record

CAPPED RENTAL, PURCHASE OPTION (To be Used When Oxygen is Provided)

As of January 1, 2006, the Center for Medicare / Medicaid included oxygen as a capped rental item. Medicare now will pay the provider, MEDOX Corporation, for a maximum of 36 months. You continue to keep and use the oxygen equipment after the 36th month and the provider, MEDOX Corporation, is still required to service and maintain your oxygen equipment every six (6) months, if needed at no additional cost to you. You will never be billed for repair, service, or replacements, such as for cannulas, as long as you have your equipment from MEDOX Corporation, regardless if your oxygen benefit with Medicare has capped out or not.

At any point you may elect to purchase your equipment from us. If you would like to purchase your equipment, please contact us.

The undersigned certifies that the information provided to MEDOX Corporation by or on behalf of the patient under Medicare (Title XV111 of the Social Security Act) and/or any other public or private health insurance is correct.

Customer/Caregiver Signature	If Caregiver, Relationship to Patient
Witness Signature	Date

This form kept in Patient Record

MEDICARE DMEPOS SUPPLIER STANDARDS

The Palmetto website 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

The products and / or services provided to you by MEDOX Corporation are subject to the supplier standards contained in the Federal regulations shown as 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:

https://www.palmettogba.com/Palmetto/Providers.nsf/docsCat/Providers~National%20Supplier%20Clearinghouse~Supplier%20Enrollment~Standards%20Compliance?open&Cat=DMEPOS%20Supplier%20Standards

Upon request we will furnish you a written copy of the standards.

This page remains with the patient

Checklist of Paperwork Provided

Customer Name_____ **Date:**_____

Item(s) received:_____

I have received the following information:

- Hours of Operation and How To Contact Us
- Welcome
- Rights and Responsibilities
- Complaint Procedure / Emergency Preparedness
- Home Safety Information + Plan of Care
- Patient Privacy Notification
- Equipment Warranty Information
- Assignment of Benefits
- Equipment/Supplies Provided
- Educational and instructional materials provided with each item such as a user manual or the educational materials provided by the manufacturer (all manuals are located on website: www.medoxcorp.com)
- Rental/Purchase Agreement

For Medicare Customers *When Applicable*:

Inexpensive or Routinely Purchased Item
Capped Rental, Purchase Option
ABN (only provided when indicated)

For All Medicare Customers:

30 CMS Supplier Standards

I understand that I must contact MEDOX Corporation of any changes in my condition or if I am hospitalized

_____ _____

Customer/Caregiver Signature If Caregiver, Relationship to Patient

_____ _____

Witness Signature Date

This form kept in Patient Record