PLEASE COMPLETE SHADED SECTIONS AND RETURN ASAP!!

LIFECARE TECHNOLOGY, INC.
113 Production Dr. Suite 2
Slidell, LA 70460
Office: (985) 649-3019 Fax: (985) 643-0422

NEW PATIENT INFORMATION

Patient Last Name: _____ Patient First Name: _____

SSI Number: _____ DOB: _____

Home #: _____ Cell #: _____

Email Address: _____

*** CANNOT SHIP TO PO BOXES. PLEASE MAKE SURE THIS IS A PHYSICAL ADDRESS***

Address: _____

City: _____ State: _____ Zip: _____

IF YOU ARE IN THE CARE OF A HOME HEALTH AGENCY PLEASE COMPLETE THIS SECTION

Referring Agency: _____ Contact Person: _____

Phone #: _____ Fax # _____

Print Patient Name: _____ Date: _____

Patient Signature: _____ Date: _____

Representative's Name: _____ Date: _____

Representative's Signature: _____ Date: _____

MEDICAL INFORMATION

Ordering Physician Name: _____

Specialty: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____

Primary Care Physician: _____

Address: _____

City: _____State: _____ Zip: _____

Phone #: _____ Fax #: _____

INSURANCE INFORMATION

Primary Insurance Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____

Member ID #: _____ Group #: _____

Secondary Insurance Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____

Member ID #: _____ Group #: _____

Print Patient Name: _____ Date: _____

Patient Signature: _____ Date: _____

Representative's Name: _____ Date: _____

Representative's Signature: _____ Date: _____

RELEASE OF INFORMATION POLICY

I authorize the release of any medical information necessary to process any insurance claims for any items provided to me by Lifecare Technology, Inc. I authorize payment of any private insurance company, government of JCAHO benefits to Lifecare Technology, Inc. I understand I am responsible for any charges not paid by my insurance company(s). Furthermore, I authorized the above named authorized representative, to act in my behalf, as my representative in all matters of business with Lifecare Technology, Inc. Your supplies will be supplied to you from Lifecare Technology, Inc. for questions, service or to order additional supplies please call 985-649-3019. Our office hours are Monday-Friday 9:00 A.M. – 4 P.M. Cash, check, Visa or Master Card is accepted for Non-Covered Items, and/or deductibles and co-payments. I understand that I am responsible for payment if I fail to update Lifecare Technology, Inc. of any changes in healthcare, insurance or living arrangements.

CONSENT TO BILL: MEDICARE / MEDICAID / PRIVATE INSURANCE

I request that a payment of Authorized (Medicare / Medicaid / Private) benefits be made on my (beneficiary) behalf to Lifecare Technology Medical Supply for any services furnished. Any holder of medical or other information about me (beneficiary) is authorized to release to the Center for Medicare & Medicaid services and /or Private Insurance, and its agents, any information needed to determine these benefits for release services.

I understand that Lifecare Technology Medical Supply reserves the right to review all agreements on an individual basis to determine the continued acceptance of assignment for Medicare and / or any other medical insurance companies. In the event of medical necessity no longer exists or my payer no longer deems any supplies to be covered I understand that I will be responsible for all payments to Lifecare Technology Medical Supply.

I have received and understand my Patient / Client of Bill of Rights, Medicare DMEPOS Supplies Standards, and Notices of Privacy. In addition, I agree that Lifecare Technology Medical Supply may contact me in the future via telephone or other means of communication regarding medical supplies.

Print Patient Name: _____ Date: _____

Patient Signature: _____ Date: _____

Representative's Name: _____ Date: _____

Representative's Signature: _____ Date: _____

HIPPA COMPLIANCE POLICY

A. OUR COMMITMENT TO PATIENT PRIVACY:

Our company is dedicated to maintaining the privacy of patient identifiable health information. In conduction our business, records regarding patients, their treatment and service will be created. All employees will respect the privacy and private nature of the business we transact with our patients. Employees may not inquire about nor discuss any patient with another employee who is not involved in the specific care of that patient. We are required by law to maintain the confidentiality of health information that identifies our patients.

All employees will be trained in HIPPA compliance and training will be updated on, at least, an annual basis.

B. IF YOU HAVE QUESTIONS ABOUT THE POLICY, PLEASE CONTACT:

C.

LIFECARE TECHNOLOGY, INC.
113 PRODUCTION DR. SUITE 2
SLIDELL, LA 70460
985.649.3019

D. WE WILL USE AND DISCLOSE PATIENT HEALTH INFORMATION IN THE FOLLOWING WAYS:

1. PAYMENT-Our Company may disclose PHI in order to bill and collect payment for services and items received. For example, we will contact health insurers to verify benefit eligibility, and we may provide details regarding treatment in order to determine what the insurer will cover, or pay for, regarding patient treatment or equipment needs. We may also disclose PHI to obtain payment information from third parties that may be responsible for such cost, such as family members, we may also use PHI to directly bill patients for services and items.
2. HEALTH RELATED BENEFITS AND SERVICES- Our company may use and disclose PHI to inform patients of health related benefits or services that may be of interest to them.
3. RELEASE OF INFORMATION TO FAMILY/FRIENDS- Our company may use and disclose PHI to a friend or family member of a patient that is helping them to pay for health care or who may assist in taking care of them.

Print Patient Name: _____ Date: _____

Patient Signature: _____ Date: _____

Representative's Name: _____ Date: _____

Representative's Signature: _____ Date: _____

4. DISCLOSURE REQUIRED BY LAW – Our company will use and disclose PHI when we are required to do so by federal, state, or local law enforcement.

E. PATIENT RIGHTS REGARDING IDENTIFIABLE HEALTH INFORMATION:

1. CONFIDENTIAL COMMUNICATIONS – Patient's have the right to request that our company communicate with them about their health and related issues in a particular manner or at a certain location. For example, they may ask that we contact them at home rather than at work. Our company will do all that it can to accommodate reasonable request regarding confidential communication within our normal business hours. When patients are in the store, we will make every effort to keep their particular health information private from other customers and employees.
2. INSPECTION AND COPIES – Patient's have the right to inspect and obtain a copy of PHI that may be used to make decisions about patient care, including patient medical records and billing records. Our company agrees to have all records ready for release within 72 hours or receiving the request. Our company will charge a minimum fee of $6.00 for up to 10 pages of copy and .25¢ for each additional page. Copy fees must be paid up front before any records will be released.
3. RIGHT TO FILE A COMPLAINT - Any patient who believes their privacy rights have been violated has the right to file a complaint with our company. The complaint should be in writing and addressed to the HIPPA Compliance Officer at our company. No patient will be penalized in any way for filing a complaint. Our company requires a response to the complaint to be made in writing within 72 hours from receipt.
4. AMENDMENT – Patient's may ask us to amend health information that they believe to be incorrect or incomplete and may request that such an amendment be held for as long as the information is kept by or for our organization. The request to amend must be in writing and must include reason to support their request. Our company may deny the request to amend information that is:
    a) Not accurate or complete;
    b) Not part of the PHI kept by or for our company;
    c) Not part of the PHI that a patient would be permitted to inspect or receive copies of;
    d) Not created by our organization;

5. RIGHT TO PROVIDE AN AUTHORIZATION FOR OTHER USES AND DISCLOSURES – Our Company will obtain written authorization from patients for uses and disclosures that are not identified by this notice or permitted by applicable law. The patient may revoke an authorization, we will no longer use or disclose the patient's PHI for the reasons described in the authorization.

F. SECURITY AWARNESS:

1. USER AUTHENTICATION – Access to computer screens which hold information related to patients is limited to:
    a) Employees of our company who work in the sales and service personnel directly involved in patient care or product ordering in the home medical or pharmacy departments and pharmacists;
    b) Accounting personnel employed by our company;
    c) Billing and receivables posting clerks employed by our company, these users will be required to use their own ID's and passwords for logging on. They will be assigned one unique ID and password per user. They may not sign on as any other user or enter information into the system on another user's ID. Any request for deletions or alterations to patient data or records must be submitted in writing to the department manager for resolution.

2. WORKSTATIONS –
    a) Paperwork related to patient information will be turned over or put away when a patient or customer approaches a workstation. At no time will an employee leave patient information out where it can be accessed by another patient or employee;
    b) Telephone conversations related to patient care are to be kept as private as possible, for example, pre-authorization request, product orders or confirmations, and billing inquires. When relaying or requesting patient information, patient's identification is to be protected, for example, intercom communicators will ask that the phone be picked up rather than provide information over the phone speakers.

Print Patient Name: _____ Date: _____

Patient Signature: _____ Date: _____

Representative's Name: _____ Date: _____

Representative's Signature: _____ Date: _____

COMPLAINT PROCEDURE

- You have the right and responsibility to express concerns, dissatisfaction or make complaints about services you do or do not receive without fear of reprisal, discrimination, or unreasonable interruption of services. Lifecare Technology, Inc.'s telephone number is 985.649.3019. When calling ask to speak with Operations Manager, Performance Improvement Coordinator, Supervisor, or the Administrator/CEO.
- Lifecare Technology, Inc. has a formal grievance procedure that ensures that your concerns shall be reviewed and an investigation started within 48 hours. Every attempt shall be made to resolve all grievances within 14 business days. You will be informed in writing of the resolution of the complaint/grievance.
- If you feel the need to discuss your concerns, dissatisfaction, or complaints with someone other than Lifecare Technology, Inc.'s staff, the state provides a Home Health "Hotline".

Assignment / Signature on File Agreement

I request that payment of authorized medical benefits be made to Lifecare Technology Medical Supply for any covered services furnished to me. In cases where Lifecare Technology Medical Supply will accept the charge determination as the full charge for the covered services, I am always responsible for the deductible, co-insurance, and unassigned uncovered services. I agree to pay Lifecare Technology Medical Supply any payment made directly to me by insurance for services provided by Lifecare Technology Medical Supply on an assigned basis. I understand that Lifecare Technology Medical Supply does not accept returned merchandise if worn, used for sanitary/hygienic purposes, or if it is disposable. It is my responsibility to inform Lifecare Technology Medical Supply if I relocate, no longer need supplies, or am admitted to a Hospital or Nursing Facility.

Print Patient Name: _____ Date: _____

Patient Signature: _____ Date: _____

Representative's Name: _____ Date: _____

Representative's Signature: _____ Date: _____

SUPPLIER STANDARDS

1. A supplier must be in compliance with all applicable federal and state licensure and regulatory requirements.
2. A supplier must provide complete and accurate information on the DMEPOS supplier application. Any changes to this information must be reported to the National Supplier Clearinghouse within 30 days.
3. An authorized individual (one whose signature is binding) must sign the enrollment application for billing privileges.
4. A supplier must fill orders from its own inventory or must contract with other companies for the purchase of items necessary to fill the order. A supplier may not contract with any entity that is currently excluded from the Medicare program, any State health care programs or from any other federal procurement or non-procurement programs.
5. A supplier must advise beneficiaries that they may rent or purchase inexpensive or routinely purchased durable medical equipment and of the purchase option for capped rental equipment.
6. A supplier must notify beneficiaries of warranty coverage and honor all warranties under applicable state law and repair or replace free of charge Medicare covered items that are under warranty.
7. A supplier must maintain a physical facility on an appropriate site and must maintain a visible sign with posted hours of operation. The location must be accessible to the public and staffed during posted hours of business. The location must be at least 200 square feet and contain space for storing records.
8. A supplier must permit CMS or its agents to conduct on-site inspections to ascertain the supplier's compliance with these standards.
9. A supplier must maintain a primary business telephone listed under the name of the business in a local directory or a toll free number available through directory assistance. The exclusive use of a beeper, answering machine, answering service or cell phone during posted business hours is prohibited.
10. A supplier must have comprehensive liability insurance in the amount of at least $300,000 that covers both the supplier's place of business and all customers and employees of the supplier. If the supplier manufactures its own items, this insurance must also cover product liability and completed operations.
11. A supplier is prohibited from direct solicitation to Medicare beneficiaries. For complete details on this prohibition see 42 CFR 424.57 (c) (11).
12. A supplier is responsible for delivery and must instruct beneficiaries on use of Medicare covered items and maintain proof of delivery and beneficiary instruction.
13. A supplier must answer questions and respond to complaints of beneficiaries and maintain documentation of such contacts.
14. A supplier 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. A supplier must accept returns of substandard (less than full quality for the particular item) or unsuitable items (inappropriate for the beneficiary at the time it was fitted and rented or sold) from beneficiaries.
16. A supplier must disclose these standards to each beneficiary it supplies a Medicare-covered item.
17. A supplier must disclose any person having ownership, financial or control interest in the supplier.
18. A supplier must not convey or reassign a supplier number (i.e., the supplier may not sell or allow another entity to use its Medicare billing number).
19. A supplier must have a complaint resolution protocol established to address beneficiary complaints that relate to these standards. A record of these complaints must be maintained at the physical facility.
20. Complaint records must include the name, address, telephone number and health insurance claim number of the beneficiary; a summary of the complaint; and any actions taken to resolve it.
21. A supplier must agree to furnish CMS any information required by the Medicare statute and implementing regulations.
22. All suppliers must be accredited by a CMS-approved accreditation organization in order to receive and retain a supplier billing number. The accreditation must indicate the specific products and services for which the supplier is accredited in order for the supplier to receive payment of those specific products and services (except for certain exempt pharmaceuticals).
23. All suppliers must notify their accreditation organization when a new DMEPOS location is opened.
24. All supplier locations, whether owned or subcontracted, must meet the DMEPOS quality standards and be separately accredited in order to bill Medicare.
25. All suppliers must disclose upon enrollment all products and services, including the addition of new product lines for which they are seeking accreditation.
26. A supplier must meet the surety bond requirements specified in 42 C.F.R. 424.57(c).
27. A supplier must obtain oxygen from a state-licensed oxygen provider.
28. A supplier must maintain ordering and referring documentation consistent with provisions found in 42 C.F.R. 424.516(f)
29. A supplier is prohibited from sharing a practice location with other Medicare providers and suppliers.
30. A supplier must remain open to the public for a minimum of 30 hours per week except physicians (as defined in section 1848 (j) (3) of the Act) or physical and occupational therapists or a DMEPOS supplier working with custom made orthotics and prosthetics.

Print Patient Name: _____ Date: _____

Patient Signature: _____ Date: _____

Representative's Name: _____ Date: _____

Representative's Signature: _____ Date: _____

PATIENT BILL OF RIGHTS AND RESPONSIBILITES

Home care patients have a right to be notified in writing of their rights and obligations before treatment is begun. The patient's family, with the patient's permission, or guardian may exercise the patient's rights when the patient has been judged incompetent. Home care providers have an obligation to protect and promote the rights of their patients to care, treatment and services within their capability and mission, and in compliance with applicable laws, regulations and
Standards: including the following rights.

YOU HAVE THE RIGHT TO:

- Be treated, and have your property treated, with dignity, courtesy and respect, recognizing that each person is a unique individual.
- Have relationships with home care providers that are based on honesty and ethical standards of conduct.
- Receive a written statement of the scope of care, treatment and/or services that are provided by Lifecare Technology, Inc. directly or through contractual arrangements.
- Reasonable coordination and continuity of services from referring agency to home medical equipment service provider, timely response when home care equipment is needed or requested and to be informed in a timely manner of impending discharge.
- Be fully informed upon admission of Lifecare Technology, Inc.'s policies, procedures, ownership or control of the local facility and the process for receiving, reviewing and resolving your complaints or concerns about your care, treatment and/or services.
- Receive complete explanations of charges for care, treatment, services and equipment, including eligibility for third-party reimbursement, charges for which you may be responsible, and an explanation of all forms you are requested to sign.
- Receive quality home care equipment and services that meet or exceed professional and industry standards regardless of race, religion, political belief, sex, social or economic status, age, disease process, DNR status or disability.
- Receive home care equipment, treatment and services from qualified personnel and to receive instructions on self care, safe and effective operation of equipment and your responsibilities regarding home care equipment, treatment and services, including pain and pain management modalities.
- Participate in decision concerning the nature and purpose of any technical procedure which will be performed and who will perform it, the possible alternatives and/or risks involved and your right to refuse all or part of the service and to be informed of expected consequences of any such action.
- Be informed of the anticipated outcomes of care, treatment and/or services and of any barriers in achieving those outcomes.
- Confidentiality of all your records (except as otherwise provided for by law or third-party payer contracts) and to review and even challenge those records and to have your records corrected for accuracy.
- Review information about to whom and when your personal health information was disclosed, as permitted under applicable law and as specified in Lifecare Technology, Inc.'s policies and procedures.
- Express dissatisfaction and to suggest changes in any service without discrimination, reprisal or unreasonable interruption of services.
- Be advised of the telephone number for the State's Abuse Hotline. The number is: 1.800.259.4990.
- Be advised of any change in the plan of care before the change is made.
- Receive information in a manner and/or language that you understand.
- Accept or refuse medical treatment while competent and to make decisions about care/services to be received should you lose competency.
- Have family members, as appropriate and as allowed by law, with your permission or the permission of your surrogate decision maker, involved in care, treatment, and/or service decisions.
- You have the responsibility to:
  a) Adhere to the plan to treatment or service established by your physician;
  b) Adhere to Lifecare Technology, Inc.'s policies and procedures.
- Participate in the development of an effective plan of care which will involve the management of pain, if appropriate.
- Provide, to the best of your knowledge, accurate and complete medical and personal information necessary to plan and provide services.
- Ask questions about your care, treatment and/or services, or to have clarified any instructions provided by company representatives.
- Communicate any information, concerns and/or questions related to pain, perceived risks in your care, treatment and/or services, and unexpected changes in your condition.
- Be available at the time deliveries are made and to allow Lifecare Technology, Inc.'s representative to enter your residence at reasonable times to repair or exchange equipment or to provide care, treatment and /or services.
- Notify Lifecare Technology, Inc. if you are going to be unavailable.
- Treat company personnel with respect and dignity without discrimination.
- Provide a safe environment for staff to provide care and services.
- Care for and safely use equipment, according to instructions provided, for the purpose it was prescribed and only for/on the patient for whom it was prescribed. Monitor the quantity of oxygen, nutritional products, medications and supplies in your home and reorder as required to assure timely delivery of the required items.
- Communicate any concerns about your/caregiver's/family member's ability to follow instructions or use the equipment provided.

- Protect equipment from fire, water, theft, or other damage. You agree not to transfer or allow your equipment to be used by any other person without prior written consent of Lifecare Technology, Inc. and further agree not to modify or attempt to make repairs of any kind to the equipment. Modifying equipment or attempting equipment repairs releases Lifecare Technology, Inc. from any liability related to the equipment and its uses, and from any resulting negative patient outcomes.
- Except where contrary to federal or state law, you are responsible for equipment rental and sale charges which your insurance company or companies do not pay. You are responsible for prompt settlement in full of your accounts unless prior arrangements have been approved by company administration.
- Lifecare Technology, Inc. should be notified of any changes in your physical condition, physician's prescription or insurance coverage. Notify Lifecare Technology, Inc. immediately of any address or telephone changes whether temporary or permanent.

Print Patient Name: _____ Date: _____

Patient Signature: _____ Date: _____

Representative's Name: _____ Date: _____

Representative's Signature: _____ Date: _____

Billing Policy

If you have insurance, we will file the claim and bill your insurance company. However, patients are responsible for any required co-payments or outstanding balances. **Payments are expected at the time of visit.**

Billing Information

BASIC POLICY: Payment for service is due in full at the time service is provided in our office. **INSURANCE**: As a courtesy, we will bill your insurance carrier for you if proper paperwork is provided to us. Co-payments and deductibles are due in full at the time of service. If you do not inform us of any special requirements or guidelines in your contract and we subsequently order services not covered, we will have no choice but to bill you directly. If an insurance carrier has not paid within **60 DAYS** of billing, the amount due will be your responsibility and will be payable in full by you. If your insurance carrier changes, you must notify us immediately.

NON-COVERED SERVICES: Some of the services we provide may be non-covered or are not considered reasonable and necessary under your policy, but have been deemed to be in the best interest by your physician. If this is the circumstance, the patient will be responsible for the balance.

PAYMENTS: If you have a balance due on your account, you will receive statements from our billing department. The letter you receive from your insurance carrier, (EOB) Explanation of Benefits, will show the amount they covered and what portion is your responsibility. Please remember that when you receive our statement, you have already received quality care from Lifecare Technology. Prompt payment upon receiving your statement is appreciated.

Re-stock Policy

In fairness to other patients and our staff, we require at least 24 HOUR notice of supply readiness. You will be charged a fee of $25.00 if you fail to honor your scheduled DOS (date of service) or do not give the necessary 24 hour notice. Insurance companies do **NOT** pay for restock of inventory, so you will be responsible to pay this before your next supplies are due.

Print Patient Name: _____ Date: _____

Patient Signature: _____ Date: _____

Representative's Name: _____ Date: _____

Representative's Signature: _____ Date: _____

FLOOD EMERGENCY PREPAREDNESS CHECKLIST

Preparation	Check
Electronic equipment is moved to a safe place	
Important documents are in a dry location	
Family valuables are in a dry location	
Gas and Electricity are turned off	
Above-ground fuel tanks are secured	
Sand bags are in most vulnerable places	
House has a flood warning system	
There is an outdoor portable generator	
Storm windows are installed	
Supplies for Flood-Ins	
Accessible stock of clean water	
Accessible stock of canned food (3 days minimum)	
Pet food	
Utensils	
Food containers	
Plastic Bags	
Knife	
Can Opener	
Water bottles	
Flashlight	
Batteries	
First Aid Kit	
Matches & Lighter	
Soap	
Disinfectant	
Water Purifiers	
Evacuation Plan	
An evacuation plan is readily available	
An evacuation map is easy accessible	
There are two planned ways to get out of any room	
Family members have learned the evacuation plan	
Family members know the emergency meeting place	
Household has practiced evacuations	
Windows are not stuck	
Window screens are easily removed	
All family members can easily open locked doors	

Hurricane Emergency Preparedness Checklist

Preparation	Check
Electronic equipment is moved to a safe place	
Important documents are in a safe location	
Gas & Electricity are turned off	
Above-ground fuel tanks are secured	
There is an outdoor portable generator	
Car has a full tank	
Storm windows are installed	
Vulnerable places are covered in tarp	
Loose shutters/outdoor furniture/trappings are secured	
Evacuation Plan	
An evacuation plan is readily available	
An evacuation map is easy accessible	
There are two planned ways to get out of any room	
Family members have learned the evacuation plan	
Family members know the emergency meeting place	
Household has practiced evacuations	
Windows are not stuck	
Window screens are easily removed	
All family members can easily open locked doors	
Supplies for Staying In	
Clean water	
Food rations (3 days)	
Water Purifiers	
Utensils/Plates/Cups/Water bottles	
Paper Towels/Plates	
Plastic Bags	
Flashlight/Batteries	
Matches/Lighters	
Tinder	
First Aid Kit	
Radio/Batteries	
Soap/Disinfectant/Bleach	
Cell Phone/Charger	

Important Phone Numbers

Emergency Contacts:

_____

_____

_____

_____

_____

Local Fire/Rescue: _____

Local Law Enforcement: _____

Nearest Hospital: _____

Utilities: _____

Property Insurance: _____

****Please initial by each stating you received the Policy/Agreement, sign the bottom and return ASAP****

NEW PATIENT CHECK LIST

____ Copy of Driver's License

____ Copies of all Insurance Cards (**Front and Back**)

____ Consent to Bill Medicare / Medicaid / Private Insurance

____ Release of Information Policy

____ Prescription from Physician

____ HIPAA Compliance

____ Complaint Procedure

____ Supplier Standards

____ Patient Bill of Rights

____ Financial Responsibility

____ Signature on File Agreement

____ Emergency Preparedness Checklist (Hurricane & Flood)

Patient Signature_____

****By signing you agree to the terms in each Policy/Agreement****

Patient Name_____

Date_____