TEAM MAKENA

17461 Derian Ave, Suite 200
Irvine, CA 92614

Tel: 949.474.1753 • Fax: 949.251.5120
Office Hours: Mon-Fri
8:00AM to 5:00PM
24 Hour Service
Toll-Free: 800.996.4001

Patient Agreement

Dr. _____ **REP:** _____
Date of Surgery: _____
Procedure: _____ **UPIN#** _____

Patient: _____
DOB: _____ SS#: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____
Cell Phone: _____

WC PATIENTS ONLY

Employer Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Office Phone: _____

Primary Ins. Co: _____
Phone: _____
Address: _____
City: _____ State: _____ Zip: _____
ID/Policy#: _____ Group#: _____
Insured: _____
Relationship to Insured: ☐ Self ☐ Spouse ☐ Child

Secondary Ins. Co: _____
Phone: _____
Address: _____
City: _____ State: _____ Zip: _____
ID/Policy#: _____ Group#: _____
Insured: _____
Relationship to Insured: ☐ Self ☐ Spouse ☐ Child
Claim#(W/C): _____ DOI: _____
Adjuster: _____

Delivery Date: _____ Rented From: _____ to _____ Stop charge date 7 day minimum rental. Overnight rental is considered as a full day.
$ _____ per day. CPM Model: _____ Serial#: _____ Thermotek Model: _____ Serial#: _____

Sale Items (Subject to applicable sales tax):

☐ Iceman ☐ Contrast	☐ TSLO Back Brace	☐ Compression Therapy (Nano)	☐ CPM Shoulder
☐ Shldr/Knee/Back/Ankle Cold Pad	☐ LSO Back Brace	☐ CPM Soft Goods	☐ CPM Knee
☐ Back Wrap	☐ Cervical/Vista Collar	☐ OTS Knee Braces	☐ CPM Other
☐ Shldr/Knee/Back/Ankle Sterile	☐ TENS/E-STIM	☐ Custom Knee Brace	☐ _____
☐ Pain Control Device	☐ Raised Toilet Seat	☐ Post-Op Knee Brace	☐ _____
☐ Ultra Sling/Abduction Pillow	☐ 3-1 Commode	☐ Front Wheel Walker	☐ Pick-up Date: _____

RENTAL TO PURCHASE OPTION

Team Makena makes every effort to provide you with equipment that is yours to keep. However, from time to time your doctor may prescribe a rental piece of equipment such as a Continuous Passive Motion Machine (CPM). If you need a CPM prescribed to you by your doctor, you may know your insurance may help pay for it. CPM's are normally rented on a daily basis. If you wish to purchase the CPM because you might need it for extended use, we will apply any daily rental rates to the purchase price. In making your decision to rent or purchase this type of equipment, you should know that you will be responsible for 20% of the service charge. You should also know that Medicare will only reimburse for a 21 day rental period, from days of surgery. If you choose the purchase option, you will be responsible for the purchase amount less the 21 day rental.

OPTION:
☐ Rental
☐ Purchase

PATIENTS RIGHTS AND RESPONSIBILITIES

1. Team Makena delivers equipment in good order and repair. Patient agrees to operate the equipment for the purpose that it was designed and intended.
2. If the equipment malfunctions, DO NOT ATTEMPT TO REPAIR IT. Call Team Makena immediately at **949.474.1753**. Our name and telephone number are on the equipment. If you have any questions as to the proper use of any product(s) provided to you by Team Makena, free consultation is available to you. The number to call is **949.474.1753**.
3. Do not allow pets or children to pull, chew, or otherwise disturb the cables and cords on the equipment.
4. I understand that the doctor or therapist is the only individual who has the authority to discontinue use of the equipment.
5. I understand that the rental equipment cannot be moved to any location other than the original set-up address without written consent/knowledge of Team Makena.
6. I agree to be responsible for any damages caused to the unit beyond normal wear and tear.
7. The Department of Health and Human Services has established a fraud hotline for Government Health Plans, i.e., Medicare, Medicaid. The number to call is **1-800-HHSTIPS**.
8. If there are any questions or concerns at any time, please contact Team Makena, **949.474.1753**.

I hereby authorize Team Makena to charge my credit card for the amount of any charges and/or added charges, which may pertain to this rental. Please Initial: _____

Credit Card Holders Name: _____ Credit Card#: _____ Expires: _____

Check#: _____ Security Deposit: _____ Deductible Due: _____ Total Due: _____

As a courtesy to the patient and insured, we will bill your insurance carrier for charges incurred herein. In the event charges are denied, you will be financially responsible for all services rendered herein. A finance charge of 1.5% per month will be added to all accounts past 30 days. Accounts over 90 days will be referred to collections for payment.

FOR PICK-UP, PLEASE CALL DURING NORMAL BUSINESS HOURS. CALLS MADE AFTER NORMAL BUSINESS HOURS WILL BE CREDITED TO NEXT BUSINESS DAYS BUSINESS.

Listed equipment setup/&/or maintained per manufacturer guidelines; functional limitations, environmental/architectural barriers/ electrical & safety checks per company policy; equipment use, warranty, availability of service & rights& responsibilities explained to patient/caregiver.

TEAM MAKENA (staff), X: _____ **Date/Time:** _____

AUTHORIZATION TO ASSIGN BENEFITS TO PROVIDER, RELEASE, ACKNOWLEDGEMENT OF INSTRUCTIONS & RETURN DEMO

I request that payment of authorized Medicare & other insurance be made on my behalf to TEAM MAKENA for products & services that they provide me. I further authorize a copy of this agreement to be used in place of a original to release to the Center of Medicare & Medicaid Services and it's agents or other payers, any information needed to determine these benefits or compliance with current healthcare standards. TEAM MAKENA bills third party payers as a courtesy; I understand that I am fully responsible for all deductible, coinsurance and disallowables. Additionally, I acknowledge receiving instructions, and have demonstrated or verbalized my understanding in the proper use & care of the equipment or supplies received today described on this document & will follow them. I understand company business hours & TEAM MAKENA representative will be contacting me regarding my financial responsibilities related to this agreement. I authorize my healthcare provider and/or any entity authorized by my healthcare provider, including those using automated dialing systems, automated messages, email, text messaging and/or other electronic communication to contact me for any reason by using any telephone number, email address and/or mailing address associated with my account. I certify that I have not rented or purchased the listed through Medicare in the past, acknowledge receipt & understand of the Company Patient Information Privacy Notice and that all information on this document is correct.

I have received TEAM MAKENA Privacy Notice. TEAM MAKENA has given me the opportunity to discuss my questions or concerns about the security and privacy of my health information.

Signature of Patient(s) X: _____ **Date/Time:** _____

If signed by caregiver or other, please list relationship and diagnosis related reason for not signing (Example: Husband, Sister, RN, etc. and "patient is unable to sign due to Parkinson's, amputation, etc,")

PRODUCT DELIVERY ACKNOWLEDGEMENT (Required by Medicare)

Signature of Patient X: _____ **Date/Time:** _____ **, I acknowledge receipt of the product referenced above on this date.**

WHITE *(HOME OFFICE)* **/ YELLOW** *(FIELD)* **/ GOLD** *(EDF)* **/ PINK** *(CUSTOMER)*

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.

Patient Health Information-Privacy Notice

Please note that we maintain paper & electronic files that may contain private information about you that may include, but are not limited to your name, address, phone number, contact person, height & weight, diagnosis, prognosis, physician(s), prescriptions, plans of service & treatment, vital signs & other clinical impressions, insurance coverage(s),equipment rented & purchased from us, credit card number(s), dates of service etc. We release, transfer & disclose the above information to third parties to facilitate appropriate provision & review of services & billing for our clients of record. These files are legal documents & are also used for education, evaluating the performance of our organization, marketing & planning purposes. We have measures in place to protect patient health information as required by law. These measures include, but are not limited to , security precautions being in place in our buildings, vehicles, billing software, transactions with government entities, vendors, consultants, surveyors, your family or appointed representative & other appropriate parties, transmission of data to third-parties, telephonic & wireless communications, maintenance, retention & destruction of data, etc. You have the right to ament, restrict, revoke consent to release, examine or obtain copies of the data that we have in your file & have released to others upon request. It you have questions concerning any of the above, please contact our Privacy Officer at the number shown on this form.

Effective 04/11/03

Team Makena, Inc. Must maintain the privacy of your personal health information and give you this notice that describes our legal duties and privacy practice concerning your personal health information. In general when we release your health information, we must release only the information we need to achieve the purpose of the use or disclosure. However, all of your personal health information that you designate will be available for release if you sign and authorization form, if you request the information for yourself, to a provider regarding your treatment, or due to a legal requirement. We must follow the privacy practices described in this notice.
However, we reserve the right to change the privacy practices described in this notice, in accordance with the law. Changes to our privacy practices would apply to all health information we maintain. If we change our privacy practices, you will receive a revised copy.

Without your written authorization, we can use your health information for the following purposes:

1. Treatment: A health care provider can disclose your protected health information to another health care provider for that provides treatment of your health care needs. For example: we may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians or other health care personnel who are involved in taking care of you.

2. Payment: In order for an insurance company to pay for your treatment, we must submit a bill that identifies you, your diagnosis, and the treatment provided to you. As a result, we will pass such health information onto an insurer in order to help receive payment for medical bills.

3. Health Care Operations: We may need your diagnosis, treatment, and outcome information in order to improve the quality or cost of care we deliver. These quality and cost improvement activities may include evaluation the performance of health care professionals, or examining the effectiveness of the treatment provided to you when compared to patients in similar situations.

In addition, we may want to use your health information for appointment reminders. For example, we may look at your medical record to determine the date and time of your next appointment with us, and then send you a reminder letter to help you remember the appointment.

4. As Required or Permitted by Law: Sometimes we must report some of your health information to legal authorities, such as law enforcement officials, court officials, or government agencies. For example, we may have to report abuse, neglect, domestic violence, or certain physical injuries, or respond to a court order.

5. For Public Health Activities: We may be required to report your health information to authorities to help prevent or control disease, injury, or disability. This may include using your medical record to report certain diseases, injuries, birth or death information, information of concern to the Food and Drug Administration, or information related to child abuse or neglect. We may also have to report to your employer certain work-related illnesses and injuries so that your workplace can be monitored for safety.

6. For Public Health Activities: We may disclose your health information to authorities so they can monitor, investigate, inspect, discipline or license those who work in the health care system for government benefit programs.

7. For Activities Related to Death: We may disclose your health information to coroners, medical examiners and funeral directors so they carry out their duties related, such as identifying the body, determining cause of death, or in the case of funeral directors, to carry out funeral preparation activities.

8. For Organ, Eye Tissue Donation: We may disclose your health information to people involved with obtaining, storing or transporting organs, eye tissue of cadavers for donation purposes.

9. For Research: Under certain circumstances, and only after a special approval process, we may use and disclose your health information to help conduct research. Such research might try might try to find out whether a certain treatment is effective in curing a illness.

10. To Avoid a Serious Threat to Health or Safety: As required by law and standards of ethical conduct, we may release your information to the proper authorities if we believe, in good faith, that such release is necessary to prevent or minimize a serious and approaching threat to your or the public's health or safety.

11. For Military, National Security, or Incarceration/Law Enforcement Custody: If you are involved with the military, national security, or intelligence activities, or you are in the custody of law enforcement officials or an inmate in a correctional institution, we may release your health information to the proper authorities so they may carry out their duties under the law.

12. For Workers' Compensation: We may disclose Your health information to the appropriate persons in order to comply with the laws related to workers' compensation or other similar programs. These programs may provide benefits for work-related injuries or illness.

13. To Those Involved With Your Care or Payment of Our Care: If people such as family members, relatives, or close personal friends are helping care for you or helping you to pay for your medical bills, we may release important health information about you to those people. The information released to these people may include your general condition, or death. You may have the right to object to such disclosed, unless you are able to function or there is a emergency. In addition, we may release your health information to organizations authorized to handle disaster relief efforts so those who care for you can receive information about your location or health status. We may allow you to agree or disagree orally to such release, unless there is an emergency. It is your duty to give you enough information so you can decide whether or not to object to the release of your health information to others involved with your care.

Note: Except for the situations listed above, we must obtain your specific written authorization for any other release of your information.

If you sign an authorization form, you may withdraw your authorization at any time, as long as your withdrawal is in writing. If you wish to withdraw your authorization, please submit your written withdrawal to ROBERT SCHULTZ, the Privacy Officer.

Medicare Supplier Standards

1. A supplier must be in compliance with all applicable Federal & State licensure & regulatory requirements.
2. A supplier must provide complete and accurate information on the DMEPOS supplier application. Any charges to this information must be reported to the National Supplier Clearing House within 30 days.
3. An authorized individual (one whose signature is binding) must sign the application for billing privileges.
4. A supplier must fill orders from it's inventory, or most 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 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 DME, and of the purchase option for capped rental equipment.
6. A supplier must notify beneficiaries of warranty, honor them under applicable law, & repair or replace free charge Medicare covered items that are under warranty.
7. A supplier must maintain a physical facility on an appropriate site.
8. A supplier must permit CMS, or it's agents to conduct onsite inspections to ascertain the supplier's compliance with standards. The supplier location must be accessible to beneficiaries during reasonable business hours, and must maintain a visible sign and posted hours of operation.
9. A supplier must maintain a primary business telephone listed under the name of the business in a local directory or a toll free number available through directory assistance. The exclusive use of a beeper, answering machine or cell phone 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 & all customers' and employee's of the supplier. If the supplier manufacturers its own items, the insurance must also cover the product liability and completed operations.
11. A supplier 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. A supplier is responsible for delivery and must instruct beneficiaries on us of Medicare covered items, maintain proof of delivery.
13. A supplier must answer questions and respond to complaints of beneficiaries, and maintain documentation of such contact.
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 supplier standards to each beneficiary to whom it supplies a Medicare-covered item.
17. A supplier must disclose to the government 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, phone # & health insurance claim number of the beneficiary, a summary of the complaint, & any actions taken to resolve it.
21. A supplier must agree to furnish CMS any information required by the Medicare statute and implementing regulations. Medicare Hotline **800-633-4227** CA DEPT of Health **916-650-6626**.
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 pharmaceuticals).
23. All suppliers must notify their accreditation organization when a new DMEPOS location is opened.
24. All supplier locations, wether 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. Must meet the surety bon requirements specified in 42 C, F, R, 424.57(c).
27. A supplier must obtain oxygen from a state-licensed oxygen supplier.
28. A supplier must maintain ordering and referring documentation consistent with provisions found in 42 C.F.R. 424.516(f).
29. DMEPOS suppliers are prohibited from sharing a practice location with certain other Medicare providers and suppliers.
30. DMEPOS suppliers must remain open to the public for a minimum of 30 hours per week with certain exceptions.

Rights, Responsibilities, Rental & Sales Agreement

Company when used in this agreement, refers to the company name listed on the front of this form. Patient refers to the person receiving the medical equipment. TITLE to the rental equipment & all parts shall remain with the Company, unless equipment is purchased & paid for in full. Patient must promptly notify Company of rental equipment malfunctions or defects & allow Company representatives to enter their premises to perform REPAIR & SERVICE. Company shall not insure or be responsible to patient or caregiver for any PERSONAL INJURY PROPERTY DAMAGE related to any product, including that caused by improper use or function thereof, the act or omission of any third party, or by any criminal act or activity, fire or act of God. Company may impose a monthly service charge of 1 ½% of the unpaid balance. Sales RETURNS may be accepted in unopened packages &/ or salable condition within three (3) days from date of original invoice with proof of purchase. Due to health department regulations, no merchandise may be accepted for return if worn next to the skin, food product, used for sanitary or hygienic purposes or if it is disposable (electrodes, wipes, creams, batteries, etc.). Special order items will require a deposit & are non-returnable. Company maintains 24-hour availability by telephone. Patient is responsible for monitoring supply levels. Should a life-threatening MEDICAL EMERGENCY arise the patient or care giver contact their local emergency services number for assistance. Patient will be communicated with in a way they can understand. Those wishing to express their concerns or comments or review, amend, review disclosure, restrict or revoke consent on their records, should contact the Company during regular business hours, Your COMMENTS will be reviewed & acted upon. Patient retains the right to refuse Company services & assumes responsibility for any consequence relating to REFUSAL of any service ordered delivered to the patient by a healthcare professional. Patient may participate in all decisions regarding service, including admission, plan of service, discharge, transfer & referral and will receive experimental treatment only with a voluntary informed consent. Patient personal healthcare information listed on the reverse side will be kept CONFIDENTIAL by Company and only used for healthcare operations, services & payment purposes. In the interest of health & safety, Company retains the RIGHT TO REFUSE DELIVERY of service at any time, however, does not discriminate. Patient has a right to respect, dignity, privacy, choice, informed consent, special communication needs, participation in the care planning process, adequate care & services, appropriate assessment and management of pain, description & charges of those services available and payment for them. Patient agrees to NOTIFY Company of any MEDICAL STATUS change such as doctor's prescription, advance directives being in place or changed, acquiring an infection requiring hospitalization or MD visit, change of residence or insurance coverage. Company is privately-owned and any financial benefits of referrals made by the Company will be disclosed to the patient. Staff always wears name tags for identification. Patient & Company agree to go to arbitration if a disagreement arises between the parties.