

SUNBELT MEDICAL RESOURCES LLC – MISSION STATEMENT

We are dedicated to exceeding our customer’s expectations in providing the greatest quality & value in home medical equipment products, supplies & services.

RIGHTS, RESPONSIBILITIES, RENTAL & SALES AGREEMENT

Company when used in this agreement, refers to SUNBELT MEDICAL RESOURCES LLC. Patient refers to the person receiving medical equipment & supplies. 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; Written manufacturer or Company warranty will apply on all sales. Company shall not insure or be responsible to patient or caregiver for any PERSONAL INJURY OR 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 1/2% of the unpaid balance. Sales RETURNS may be accepted in unopened packages &/or salable condition within three (3) business 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 caregiver contact their local emergency services number for assistance. 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, of anticipated outcomes of service and of any barriers in outcome achievement, 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, knowledge of service limitations, 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. Patient will be communicated in a way they can understand. Those wishing to express their concerns or comments regarding our services or review, amend, review disclosure, restrict or revoke consent on their records without fear of reprisal, should contact the Company during regular business hours, your COMMENTS will be reviewed and you will be contacted in writing within five business days and we will resolve your issue within fourteen business days. We are approved by SC Medicaid 803 788-7622; should we be unable to resolve an issue, please feel free to contact them. Our staff wear name tags for identification. Patient & Company agree to go to arbitration if a disagreement arises between the parties.

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 amend, restrict, revoke consent to release, examine or obtain copies of the data that we have in your file & have released to others upon request. If you have questions concerning any of the above, please contact our Privacy Officer at Toll free 1-855-649-1233.

ASSIGNMENT OF BENEFITS TO COMPANY, CONSENT TO RELEASE HEALTH INFORMATION & AGREEMENT TO PAY

Patient requests that payment of all authorized benefits be made on their behalf to Company for products & services that have been provided to patient. In the event benefit payments due Company are paid directly to Patient, the payee shall immediately endorse and remit to Company all such benefit payment checks. Patient further authorizes a copy of this agreement to be used in place of the original to release to The Centers for Medicare & Medicaid Services and its agents or other payers, any information needed to determine these benefits or compliance with current healthcare standards. The Patient authorizes all medical personnel and/or entities involved in the Patient’s treatment to disclose to Company any and all information concerning the Patient’s medical history and condition that may assist the Company in processing claims for items provided to the Patient by the Company. The Patient hereby authorizes healthcare providers to rely on this Consent to Release Health Information without the need for a separate release authorization to release the information for treatment, payment and health care operations purposes. If this was a pick-up or return of equipment, I acknowledge that I have returned the item(s) listed to your staff. Company bills third-party payers as a courtesy; I understand that I am fully responsible for all deductibles, coinsurance & non-allowable. In the event of default in payment beyond 30 days, a \$15 late fee will be charged and the Company may pursue other remedies available.

Signature of patient or authorized representative _____ **Date** _____

If signed by caregiver or other, please list relationship and diagnosis related reason for not signing (Example: Husband, Sister, R.N., etc. & “patient unable to sign due to Parkinson’s, Amputation, etc.”)

ACKNOWLEDGMENT OF INSTRUCTIONS, RETURN DEMONSTRATION & UNDERSTANDING OF COMPANY INFORMATION

Patient acknowledges receiving instruction and has demonstrated or verbalized understanding in the proper use & care of the equipment or supplies received & will follow them. Patient understands Company business hours & understands that a SUNBELT MEDICAL RESOURCES LLC representative may be contacting patient regarding financial responsibilities related to this agreement. Patient certifies that they have not rented or purchased the equipment listed on this agreement through Medicare in the past, Patient acknowledges receipt & understanding of the Company Patient Health Information Privacy Notice & that all information on both sides of this document is correct.

Signature of patient or authorized representative _____ **Date** _____

If signed by caregiver or other, please list relationship and diagnosis related reason for not signing (Example: Husband, Sister, R.N., etc. & “patient unable to sign due to Parkinson’s, Amputation, etc.”)

Listed equipment set-up &/or maintained per manufacturer guidelines; functional limitations, environmental/architectural barriers/electrical & safety checks per Company policy; equipment use, warranty & manufacturer information, availability of service & this document explained to patient/caregiver, as appropriate: