

PULMONARY PROVIDERS GROUP, INC.

DME – durable medical equipment provider

4521W. Lawrence Ave. Suite 110 Chicago, Il 60630. 847 824-0500 24 Hours Service 847 226-3049
Toll Free 877 214-0400

CLIENT/PATIENT SERVICE AGREEMENT and ACKNOWLEDGEMENT

Client/patient:

Authorization/Consent for Care/Service: I have been informed of the home care options available to me and of the selection of providers from which I may choose. I authorize Pulmonary Providers Group, Inc. under the direction of the prescribing physician, to provide home medical equipment, supplies and services as prescribed by my physician.

Assignment of Benefits/Authorization for Payment: I hereby assign all benefits and payments to be made directly to Pulmonary Providers Group, Inc. for any home medical equipment, supplies and services furnished to me in conjunction with my home care. I authorize Pulmonary Providers Group, Inc. to seek such benefits and payments on my behalf. It is understood that, as a courtesy, Pulmonary Providers Group, Inc. will bill Medicare/Medicaid or other federally funded sources and other payors and insurer(s) providing coverage, with a copy to Pulmonary Providers Group, Inc. I understand that I am responsible for providing all necessary information and for making sure all certification and enrollment requirements are fulfilled. Any changes in my insurance coverage must be reported to Pulmonary Providers Group, Inc. within 30 days of the event.

Release of Information: I hereby request and authorize Pulmonary Providers Group, Inc. the prescribing physician, hospital, and any other holder of information relevant to service, to release information upon request, to Pulmonary Providers Group, Inc. any payor source, physician, or any other medical personnel or agency involved with service. I also authorize Pulmonary Providers Group, Inc. to review medical history and payor information for the purpose of providing home health care.

Financial Responsibility: I understand and agree that I am responsible for the payment of any and all sums that may become due for the services provided. These sums include, but are not limited to, all deductibles, co-payments, out-of-pocket requirements, and non-covered services. If for any reason and to any extent, Pulmonary Providers Group, Inc. does not receive payment from my payor source, I hereby agree to pay Pulmonary Providers Group, Inc. for the balance in full, within 30 days of receipt of invoice. All charges not paid within 45 days of billing date shall be assessed late charges. I am liable for all charges, including collection costs and all attorneys' cost. I am responsible for all charges regardless of my payor unless my agreement with my health plan holds me harmless. I understand that in the event services are deemed not reasonable and necessary, payment may be denied and that I will be fully responsible for payment. Failure to pay Invoices in a timely manner may lead Pulmonary Providers Group, Inc. to initiate collection proceedings or pickup delivered equipment. I understand that if I have questions about insurance coverage or the amount I may owe, I can contact Pulmonary Providers Group, Inc. customer service prior to accepting delivery.

Returned Goods: I understand that, due to Federal and State Pharmacy Regulations most items prescribed for home health care cannot be re-dispensed. Therefore, delivered items cannot be returned for credit. Home Medical Equipment that is rented will be returned after the physician has discontinued service. Sale items cannot be returned. Pulmonary Providers Group, Inc. must be notified within 24 hours of the set-up if any equipment is defective. In the case of defective equipment, an exchange will be made for the defective item.

Client/Patient Handouts: I acknowledge that I have received a copy of the Client/patient Handouts, which contains Client/patient Rights and Responsibilities, Supplier Standards, Home Safety Information, HIPPA Privacy Standards, Warranty/Rent Purchase Information, Emergency Planning, and Advance Directive Information. I acknowledge that the information in the Client/patient Handouts has been explained to me and that I understand the information. I understand my right to formulate and to issue Advance Directives to be followed should I become incapacitated. I will furnish Pulmonary Providers Group, Inc. with a copy of such document.

Grievance Reporting: I acknowledge that I have been informed of the procedure to report a grievance should I become dissatisfied with any portion of my home care experience. I understand that I may lodge a complaint without concern for reprisal, discrimination, or unreasonable interruption of service. To place a grievance, please call 847-824-0500 and speak to the Customer Services Supervisor. If your complaint is not resolved to your satisfaction within 5 working days, you may initiate a formal grievance, in writing and forward it to the Compliance Officer. You can expect a written response within 14 working days of receipt. All complaints will be logged and the outcome noted for annual review and evaluation by the company.

Home Health Hotline: You may also make inquiries or complaints about this company by calling your local Social Services Department and/or our accrediting body HQAA. **(800) HHS-TIPS or HQAA-866-909-4722**

Acknowledgement of receipt: I acknowledge that Pulmonary Providers Group, Inc. has discussed this information with me and provided me with a copy of patient handouts regarding all of the above.

Client/patient: _____ Date: _____

Witness: _____ Date: _____