Health Quest Medical Supply Inc. 97-12 Rockaway Blvd. #6 Ozone Park, NY 11417 (718)532-4100

PATIENT SERVICE AND AGREEMENT

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 HQ Medical Supply 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 HQ Medical Supply for any home medical equipment, supplies and services furnished to me in conjunction with my home care. I authorize HQ Medical Supply to seek such benefits and payments on my behalf. It is understood that, as a courtesy HQ Medical Supply will bill Medicare/Medicaid or other federally funded sources and other payers and insurer(s) providing coverage, with a copy to HQ Medical Supply. 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 the policy must be reported to HQ Medical Supply within 30 days of the event. I have informed by HQ Medical Supply of the medical necessity for the services prescribed by my physician. 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 the payment.

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, HQ Medical Supply does not receive payment from my payer source, I hereby agree to pay HQ Medical Supply for the balance in full within 30 days of receipt of invoice. All changes not paid within 45 days of billing date shall be assessed late charges. I am liable for all charges, including collection cost and all attorney costs. I am responsible for all charges regardless of my pay unless my agreement with my health plan holds me harmless.

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

Patient Handouts: I acknowledge that I have received a copy of the patient handouts which contains Patient's Right's and Responsibilities, Supplier Standards, Home safety Information, HIPAA Privacy standards, Emergency planning and Advance Directive information. I acknowledge that the information in the 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 HQ Medical Supply Inc. with a copy of said document.

Grievance Reporting: I acknowledge that I have been informed of the procedure to repot 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 718-532-4100 and speak to customer service supervisor. If your complaint is not resolved to your satisfaction within 5 business days, you may initiate a formal grievance in writing and forward it to the Governing Body. You can expect a written response within 14 business days or receipt.

Home Health Hotline: You may also make inquires or complaints about this company by calling your New York City Department of Consumer Affairs Department and/or The Compliance Team Exemplary Provider Accreditation at (215) 654-9110.

Patient's Personal Information

Last Name: ______________________ First Name: ______________________ M.I___

Address: ______________________ City: ______________ State: _______ Zip__________

Home Phone: ______________________ Alternate Phone: ______________________

Date of Birth______________________ Sex: [ ] Male or [ ] Female Height: ____________ Weight: __________

Emergency contact name ______________________ Relationship ______________ Phone______________

I understand and hereby acknowledge that the above information is truthful and accurate. I hereby give permission for the release of any information to patient requesting my medical date for the purpose of the analysis of further medical review and/or insurance reimbursement. If my insurance company denies payment for any reason, I am responsible for my outstanding fees.

Patient Signature: ______________________________ Date: ______________________

100 Wall Street, Suite 2502, New York, NY 10005
Tel 718.369.0012 Fax 718.287.1229
consents@accessintegra.com

DELIVERY TICKET

PATIENT (first/last name)________________________ DATE ____________

SHIP TO

NAME (first/last) ____

ADDRESS ____

CITY ____________________ STATE __________ ZIP ____________

PHONE ________________________________

EQUIPMENT TO DELIVER

DESCRIPTION	SERIAL NUMBER	QUANTITY

OTHER

______________________ / ____________
PATIENT'S SIGNATURE / DATE

____
NAME (if other than patient)

______________________ / ____________
COMPANY REPRESENTATIVE'S SIGNATURE / DATE

____
COMPANY REPRESENTATIVE'S NAME