



Pal-Med, Inc.

ASSIGNMENT OF BENEFITS AND SIGNATURE AUTHORIZATION FORM

PATIENT INFORMATION

PATIENT NAME		DATE OF BIRTH	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
ADDRESS	CITY	STATE	ZIP
INSULIN (IDDM) <input type="checkbox"/>		NON INSULIN (NIDDM) <input type="checkbox"/>	
PATIENT MEDICARE OR SS NO.	PHONE NUMBER ()	PLEASE INCLUDE AREA CODE	EMPLOYED ? <input type="checkbox"/> YES <input type="checkbox"/> NO
SPOUSE'S NAME (IF INSURED UNDER SPOUSES' POLICY)		SS#	PHYSICIANS FAX #. ()
PHYSICIANS NAME AND ADDRESS		Physician UPIN	PHYSICIANS PHONE NUMBER ()

INSURANCE INFORMATION

#1 PRIMARY INSURANCE POLICY

#2 SECONDARY INSURANCE POLICY

NAME OF INSURANCE COMPANY	NAME OF INSURANCE COMPANY
ADDRESS	ADDRESS
CITY	CITY
STATE	STATE
ZIP	ZIP
INSURANCE CO. PHONE NUMBER (IF KNOWN)	INSURANCE CO. PHONE NUMBER (IF KNOWN)
EFFECTIVE DATE OF POLICY	EFFECTIVE DATE OF POLICY
MEDICAID OR PRIVATE INSURANCE POLICY NO.	MEDICAID OR PRIVATE INSURANCE POLICY NO.

SIGNATURE AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I, the undersigned, do hereby assign my Medicare/Medicaid and/or Private insurance benefits to Pal-Med, Inc., who is the supplier of my home diabetic supplies and request that payment under the medical insurance program be made to same. I also agree that I will pay any deductible or co-pay not covered by my insurance.

Further, I do agree to authorize the release of information pertaining to my home supplies to any directly affected insurance company, governmental agency or other entity requesting the same.

PATIENT'S SIGNATURE

DATE

P.O. Box 2538
West Columbia, SC 29171

Phone 1-888-472-5633

Fax 1-803-791-9019

1. A supplier must be in compliance with applicable Federal & State licensure & 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 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 its own inventory, or must contract with other companies for the purchase of items necessary for 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 purchase inexpensive or routinely purchased DME, and of the procedure for capped rental equipment.
6. A supplier must notify beneficiaries of warranty, honor all warranties under applicable law, & 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.
8. A supplier must permit CMS, or its agents to conduct on-site 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 posted hours of operation.
9. A supplier must maintain a primary business telephone listed in 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 and all customer's and employees of the supplier. If the supplier manufactures its own items, this insurance must cover the product liability and complete 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 use of Medicare covered items, maintain product history.
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, 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 to another supplier 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 number, 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.

Rights, Responsibilities, Rental & Sales Agreement

Company when used in this agreement, refers to PAL-MED, INC. 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 from 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 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 charge of 1 1/2% of the unpaid balance. Sales RETURNS will be accepted in unopened packages &/or salable condition within three (3) days of 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 hygiene purposes or if it is disposable (electrodes, wipes, creamers, etc.). Special order items will require a deposit & are non-returnable. 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 has 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 care including admission, plan of service, anticipated outcomes of service and of any barriers in outcome achievement. Patient will receive experiential treatment only with a voluntary informed consent. Patient personal healthcare information listed on the reverse 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 MEDICAL STATUS change such as doctor's prescription, advanced directives being in place or changed, acquiring 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, amend, review disclosure, restrict or revoke consent on their records, should contact the Company during regular business hours, your COMMENTS will be reviewed and you will be contacted within the business days. We will attempt to resolve your issue as soon as possible. We are an approved Medicare (800 633-4227) provider. Patient & Company agree to go to arbitration if a disagreement arises between the parties. Mission Statement We are dedicated to exceeding our customer's expectations in providing the greatest quality value in healthcare related products, supplies and services.

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, services & treatment, vital signs, other clinical impressions, insurance coverage(s), equipment rented & purchased from us, credit card number(s), dates of use, 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 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, storage, transactions with government entities, vendors, consultants, surveyors, your family or appointed representative & other appropriate parties, transmission to third-parties, telephonic & wireless communications, maintenance, retention & destruction of data, etc. You have the right to amend, restrict, revoke consent to release information, obtain copies of the data that we have in your files & be released to others upon request. If you have questions concerning any of the above, please contact our Privacy Officer at the number shown on this form. Effective 04/11/03

Listed equipment set-up &/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:

PAL-MED, INC. Staff X _____ Date _____

RECEIVED BY, ACKNOWLEDGMENT OF INSTRUCTIONS & RETURN DEMO : I acknowledge receiving instruction, via demonstrated or verbalized my understanding in the proper use & care of the equipment I have received today & described on this document & will follow it. I understand Company business hours. If this was a pick-up or return of equipment I acknowledge that I have returned the item(s) listed to your staff. I acknowledge receipt & understanding of the Company Patient Health Information Privacy Notice, Rights & Responsibilities, Medicare Supplier Standards & that all information on both sides of this document is correct:

Signature of Patient _____ Date _____

AUTHORIZATION TO ASSIGN BENEFITS TO PROVIDER & RELEASE: I request that payment of authorized Medicare benefits be made on my behalf to PAL-MED, INC. for products & services that they have provided me. I understand that PAL-MED, INC. representative will be contacting me regarding my financial responsibilities related to this agreement. I further authorize 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 benefits or compliance with current healthcare standards. PAL-MED, INC. bills third-party payers as a courtesy; I understand that I am fully responsible for all deductibles, coinsurance & disallowable (unpaid items). I acknowledge that Medicare or other insurance has not purchased or rented the same or similar items, listed above, in the past:

Signature of Patient _____ Date _____

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