Home Medical Equipment and Respiratory Services

We are pleased to provide a complete range of top quality, cutting edge Respiratory and Durable Medical Equipment.

Our goal is to be ...
“Your foundation for health at home”
Dear Patient,

Cornerstone Medical Services and the family of companies is committed to providing you, our
patient, with quality clinical care, quality products, and exceptional customer service. Meeting
and exceeding your expectations is our goal and we rely on your feedback to help us improve
customer service.

In the coming weeks, you may receive an automated patient satisfaction survey telephone
call. Please take a moment to tell us how you think Cornerstone has provided its services. The
automated message will ask for you to rate us by using the numbers on your phone. The rating
goes from “10” with being the highest score or very good service, and “0” with very poor. If
you are unable to complete the survey using the telephone or prefer to take the survey using
the internet, please contact your local office and provide us with your email address. A link to
the patient satisfaction survey will be sent to your email. A sample patient satisfaction survey
can be found in the patient booklet.

Cornerstone Medical Services’ goal is to have a 100% rating overall

Our standards for quality service are the highest in the industry. We believe that any score less
than a 10 does not meet those standards. If you feel for any reason that we did not earn a 10 in
any category, please call your local branch so we can improve services provided to you.

Thank you for taking the time to complete the patient satisfaction survey. Your input and
comments help make Cornerstone Medical Services and its family of companies the premier
provider of home medical equipment in the industry.

Respectfully,

Robert C. Lybarger
Vice President of Operations
Dear Valued Patient,

Thank you for choosing Cornerstone Medical Services and the family of companies for your home medical supplies. We realize you have a choice in care providers and we appreciate the opportunity to serve you. We are excited to tell you about our new supply reorder process. Our Supply Fulfillment Program is designed to provide a higher level of service and help you obtain the best possible results from your therapy and equipment. This program is now available for CPAP/BiPAP, Diabetes, TENS, and Nebulizer supplies.

This new, automated interactive process will contact you every few months and ask you a few short questions related to your health, equipment and supplies. It takes less than 5 minutes to complete your assessment and reorder. Please listen to the questions and simply press the numbers on your telephone’s keypad to reply.

If you are in need of any supplies prior to receiving a call from us, you can complete your assessment by calling us any time, day or night, at 866-582-9615 (toll-free) or by mailing/faxing us the completed form below. We hope you’ll love the ease and convenience of our new contact solution as much as we do.

<table>
<thead>
<tr>
<th>Billing Code</th>
<th>Description</th>
<th>Common Allowed Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>A7030</td>
<td>FULL FACE MASK</td>
<td>1 PER 3 MONTHS</td>
</tr>
<tr>
<td>A7031</td>
<td>FULL FACE CUSHION</td>
<td>1 PER MONTH</td>
</tr>
<tr>
<td>A7034</td>
<td>NASAL MASK</td>
<td>1 PER 3 MONTHS</td>
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<tr>
<td>A7032</td>
<td>NASAL CUSHION</td>
<td>2 PER 1 MONTH</td>
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<tr>
<td>A7033</td>
<td>NASAL PILLOW</td>
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<td>A7027</td>
<td>HYBRID MASK</td>
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<td>A7028</td>
<td>HYBRID ORAL CUSHION</td>
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<td>HYBRID NASAL PILLOW</td>
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</tr>
<tr>
<td>A7044</td>
<td>ORAL MASK</td>
<td>1 PER 3 MONTHS</td>
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</table>

Patient Name __________________________________ Date of Birth __________________________

Supplies Requested (please list specifically what items you need and quantity needed)
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Please list the dysfunction of your current supplies (example: worn out, bacteria build-up, etc)
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Has there been any change to your address or insurance in the last 30 days or since your last order? YES _____ NO _____ If yes, please include updates with this form.

Signature __________________________ Date __________________________

Thank you. Your supplies will be mailed to you within 7 business days upon receipt of this form. If there are any questions or a delay in shipment, a Fulfillment Specialist will contact you.

Rev. 1/14
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Equipment is available for rental or purchase, our extensive inventory includes the item that patients need and prefer.

Oxygen Delivery Systems
(Liquid, Conservers)
Bilevel/CPAP Therapy
Nebulizers
Pulse Oximeters
Hospital Beds
Wheelchairs
Negative Pressure Wound Therapy
Aids to Daily Living

Cornerstone Medical Services and the family of companies does not discriminate against any person on the basis of race, color, national origin, disability, or age in admission, treatment, or participation in its programs, services and activities, or in employment. For further information about this policy, contact: Judy Schuler, Chief Clinical Officer, 513-576-0262, 800-750-0750.
Mission Statement:

Is to exceed the expectations of our customers, associates and shareholders in the delivery of health care and support services in a way that a caring family provides.

Core Values:

<table>
<thead>
<tr>
<th>Accountability</th>
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<tr>
<td>Taking ownership to achieve desired results</td>
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<table>
<thead>
<tr>
<th>Compassion</th>
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<tr>
<td>Caring for others through patience, kindness, tolerance and understanding</td>
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<table>
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<tr>
<th>Diversity</th>
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<tr>
<td>Appreciating unique skills and abilities, and treating others with respect, resulting in collaboration, cooperation and productivity</td>
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<table>
<thead>
<tr>
<th>Integrity</th>
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<tr>
<td>Adherence to moral and ethical principles, soundness of character, honesty and fairness</td>
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<table>
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<tr>
<th>Passion</th>
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<tr>
<td>Commitment to excellence drives us to be the very best in all we do</td>
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<table>
<thead>
<tr>
<th>Quality</th>
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<tr>
<td>Providing excellent care and service to all with whom we come in contact.</td>
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BASIC HOME SAFETY GUIDELINES

Fire Safety
- Develop and practice exit procedures in case of a fire.
- Install smoke detectors and check batteries annually.
- No smoking in a house where oxygen is in use. Post oxygen sign.
- Have a fire extinguisher for home use.

Electrical Safety
- Use equipment only as instructed.
- Use extension cords, power strips, and space heaters properly.
- Keep equipment clean and dry.
- All equipment must be properly grounded.
- Notify the power company of the presence of life support equipment.

Environmental Safety
- Avoid use of throw rugs and keep wires and cords out of walking areas.
- Create a furniture layout for easiest access to other rooms.
- Keep floors uncluttered.
- Use a night light.

Bathroom Safety
- Install handrails in shower, tub and around commode, if necessary.
- Wear shoes or slippers with non-skid soles.
- Use non-skid tips on walkers, canes, or crutches.
- Always use wheel locks on wheelchairs for transfers.

Medication Safety
- Store medications and supplies in a safe, dry place.
- Only prepare medicine as instructed by a nurse, pharmacist, or physician.
- Always read medication labels carefully before taking.
- Throw away all needles in a sharps container.
- Do not recap needles.
- Do not take medications that have expired.

Hand Washing
- Hand washing is the single most effective means of preventing the spread of infections.
- Hands should be washed:
  - Before handling clean or sterile equipment.
  - Before and after touching open wounds.
  - Before eating.
  - After using the rest room.
  - After handling soiled or contaminated items.
SAFETY GUIDELINES

Surviving a Fire in Your Home

Take the time now to prepare – it can save lives!

An Ounce Of Prevention…

Smoke Alarms
- Install a smoke alarm outside of each sleeping area and on each additional level of your home.
- Install smoke alarms INSIDE sleeping areas if people sleep with their doors closed.
- Test smoke alarms once a month by pressing test buttons.
- If an alarm fails the test or starts making beeping noises, replace batteries immediately.
- Replace ALL smoke alarm batteries at least once a year.

Fire Extinguishers
- Consider purchasing one or more fire extinguishers to keep in your home.
- Read the instructions to understand how your fire extinguisher works, and make sure all family members understand how to use it.
- Read the instructions to find out how to check if your extinguisher is in working order, and how frequently it needs to be checked.

Escape Ladders
- Consider installing escape ladders for upstairs rooms.
- Learn how to use your escape ladder.
- Store ladders close to windows.

Flashlights
- Keep flashlights throughout your house and make sure everyone knows where they are located.
- Check batteries regularly.

Planning Can Prevent Panic

Escape Routes
- Figure out at least two ways for escaping for every room in your home.
- Everyone living in your home should be familiar with these escape routes.

Practice
- At least twice a year, practice using your escape plans.

- Practice crawling because if there is a fire in your home you may need to escape by crawling under smoke, where the freshest air will be.

Meeting Place
- Decide on a location where everyone will meet outside your home after escaping from a fire.
- A meeting place is important so that you can quickly see if everyone has escaped.

If A Fire Occurs…

Making Your Escape
- If there is smoke or fire in one escape route, use another route.
- If there is no way to avoid smoke, remember to stay low and crawl under the smoke, where the freshest air will be.
- If you want to escape by opening a closed door, FIRST check to see if the door feels warm before opening it. If it is warm, do NOT open the door. Instead. Use another route.

Blocked Escape Routes
If all of your escape routes are blocked by smoke, heat, or flames:
- Stay in the room and keep any doors closed.
- Keep out smoke by piling rugs, blankets or pillows along the bottom of any doors.
- If there is a phone in the room, call 911 and tell them where you are.
- Signal out a window for help using a brightly colored cloth, sheet, towel, or flashlight.
- Stay as close to the floor as possible, near a window or door.

After Escaping
- Go to a neighbor’s house and call 911 as soon as possible.
- NEVER go back inside a burning house. Once you’re outside, stay outside!
- When firefighters arrive, tell them if you think anyone is still inside.
SAFETY GUIDELINES

Tips To Avoid Falling

Taking a tumble is the most frequent accident that occurs to seniors. Reduce your chances of falling by making home improvements and changing habits.

Look Around The Home

Floors
- Keep the areas where you walk free from clutter, electrical and telephone cords, and other small objects that might be easily overlooked.
- Secure loose rugs and mats with carpet tape or attach non-slip backing.
- For tile or wooden floors, avoid wax or use non-skid wax.
- Stairs should have flat surfaces. Repair holes or tears in carpeting and make sure it is well attached.
- Eliminate raised thresholds if possible or make them highly visible.

Lighting
- Make sure it’s easy to turn on a light BEFORE entering every room in your home.
- Keep night lights turned on in hallways, bedrooms, and bathrooms.
- Make sure you can easily turn on a light while in bed, before getting up.
- Put flashlights in convenient locations throughout your home, and check batteries regularly.
- Light switches should be available at both the top and bottom of all stairs.
- Stairway lighting should be bright enough to clearly see all steps.

Bathrooms
- Tub and shower floors should have non-skid surfaces (strips or mats).
- Consider installing grab bars inside the bath or shower areas and next to the toilet.
- Consider installing a raised toilet seat.

Kitchen
- Frequently used items should be kept on lower shelves or in easy to reach places.
- You should have a sturdy step stool that is easy to use, preferably with a handrail. Do NOT stand on a chair to reach anything.

Stairs
- Sturdy handrails should be installed in all stairways and kept in good repair.
- Steps should have flat surfaces and be kept in good repair.
- All steps should have handrails, preferably on both sides of the steps.
- For better traction, steps can be painted with a mixture of sand and paint.
- During the winter, keep all entrances and sidewalks clear of snow and ice.
- All entrances should be well lit.
- Consider installing ramps (with handrails).

Reconsider Personal Habits
- When walking, stay alert to unexpected obstacles – cords, furniture, pets, toys, etc.
- Avoid rushing to answer phones or the door.
- Take time to make sure your balance is steady before sitting up or standing.
- Wear shoes that are supportive and snug fitting, with low heels and non-slippery soles.
- Don’t walk around with only socks on your feet.
- If carrying packages, make sure your view isn’t blocked and that you have a hand free for opening doors, holding onto railings, or steadying your balance.
- Keep alert for uneven, broken, or slippery pavement, sidewalks, and ramps.
- Don’t rush to cross streets, especially if wet or icy.
- Consider using a cane or walker.
- Find out if your medications might make you feel dizzy, drowsy, or unsteady.
- If you live alone, keep in regular contact with friends, family, or neighbors.

For Emergencies
- Keep emergency phone numbers posted where they can be easily seen. Consider whether they will be visible if you fall.
- Make sure you can easily reach a phone when in bed.

If You Fall
1. **Call 911** and other emergency contacts.
2. Stay warm by covering up with a blanket, coat, towel, rug, or whatever you can reach.
3. Consult a doctor even if you don’t think you’ve been seriously hurt. Falling may indicate problems with medications or be a symptom of illness or a condition that needs treatment.
EMERGENCY PLANNING FOR THE HOME CARE PATIENT

This pamphlet has been provided to help you plan your actions in case there is a natural disaster where you live.

Midwestern states are prone to occasional natural disasters like tornadoes and floods. All areas of the U.S. are also subject to man-made disasters such as power outages and terrorist attacks.

As part of receiving care or services in the home, you should think about what you would do in the event of an emergency.

Our goal is to help you plan so that we can try to provide you with services during an emergency.

Know What to Expect

If you have recently moved to this area, take the time to find out what types of natural emergencies are common and have occurred.

Find out what, if any, time of year these emergencies are more prevalent.

Find out when you should evacuate and when you shouldn't.

Your local Red Cross, local law enforcement agencies, local news and radio stations usually provide excellent information and tips for planning.

Know Where to Go

You should know the location of the closest emergency shelter and how to get there.

Emergency shelters are opened to the public during voluntary and mandatory evacuation times. They are usually the safest places for you to go, other than a friend or relative's home in an unaffected area.

Know What to Take With You

If you are going to a shelter, there will be restrictions on what items you can bring with you. Not all shelters have adequate storage facilities for medications that need refrigeration.

We recommend that you call ahead (before an emergency occurs), and find out which shelter in your area will let you bring your medications and medical supplies. In addition, let them know if you will be using medical equipment that requires an electrical outlet.

During our planning for a natural emergency, we will contact you and deliver, if possible, at least (3) to (7) days of oxygen. Bring all your medication and supplies with you to the shelter.

How to Reach Us If There Are No Phones

How do you reach us during a natural emergency if the phone lines don't work? How would you contact us in the event of a natural emergency? We will attempt to contact category II and III patients to provide you with the number of our cellular phone(s). (Cellular phones frequently work even when land line phones do not.)
If you cannot call our cellular phone, you can try to reach us by having a family member or friend call us from his/her cellular phone. (Many times cellular phone companies set up communication centers during natural disasters. If one is set up in your area you can ask them to contact us.)

If the emergency is unforeseen, we will try to locate you by visiting your home, or by contacting your home nursing agency. If travel is restricted due to damage from the emergency, we will try to contact you through local law enforcement agencies.

An Ounce of Prevention . . .

We want to prepare you for an emergency ahead of time rather than wait until it has happened and then send you the supplies you need.

To do this, we need you to give us as much information as possible before the emergency. We may ask you for the name and phone number of a close family member, or a close friend or neighbor. We may ask you where you will go if an emergency occurs. Will you go to a shelter, a relative's home? If your doctor has instructed you to go to a hospital, which one?

Having the address of your evacuation site may allow us to service your therapy needs or use another company.

Helpful Tips

- Have a cooler and ice or freezer gel-packs available to transport your medication.
- Have your medication information and teaching modules together and take them with you if you evacuate.
- Pack one week's worth of supplies in a plastic-lined box or waterproof tote bag or tote box. Make sure the seal is watertight.
- Put antibacterial soap and paper towels into your supply kit.
- Have waterless hand disinfectant. It comes in very handy if you don't have running water.
- If you are going to a friend's or relative's home during evacuation, leave their phone number and address with our company and your home nursing agency.
- When you return to your home, contact your home nursing agency and our company so we can schedule a visit and provide supplies you need.

For More Information

There is much more to know about planning for and surviving during a natural emergency or disaster. To be ready for an emergency, contact your local American Red Cross or Emergency Management Services agency.

An Important Reminder!

*During any emergency situation, if you are unable to contact our company and you are in need of your prescribed medication, equipment, or supplies you must go to the nearest emergency room or other treatment facility for treatment.*
PATIENT BILL OF RIGHTS AND RESPONSIBILITIES

We believe that all patients receiving services from us should be informed of their rights. Therefore, you are entitled to:

1. Receive reasonable coordination and continuity of services from the referring agency for home medical equipment services.
2. Receive a timely response from our company when homecare services/care is needed or requested.
3. Be fully informed in advance about service/care to be provided and any modifications to the service/care plan.
4. Participate in the development and periodic revision of the plan of service/care.
5. Be fully informed of the service/care or treatment offered and either consent or refuse the service/care of treatment.
6. Be informed in advance of the charges, including payment for service/care expected from third parties and any charges for which you will be responsible.
7. Have your property and person treated with respect, consideration, and recognition of patient dignity and individuality.
8. Be able to identify visiting staff members through proper identification.
9. Voice grievances/complaints or recommend changes in policy, staff or service/care without restraint, interference, coercion, discrimination or reprisal.
10. Choose a health care provider.
11. Confidentiality and privacy of all information contained in your health record.
12. Receive appropriate service/care without discrimination in accordance with physician orders.
13. Be fully informed of your responsibilities.
15. Be informed of your rights under state law to formulate advanced care directives.
16. Be informed of anticipated outcomes of service/care and of any barriers in outcome achievement.

YOUR RESPONSIBILITIES

1. Patient agrees that rental equipment will be used with reasonable care, not altered, or modified, and returned in good condition (normal wear and tear excepted).
2. Patient agrees to promptly report to us any malfunctions or defects in rental equipment so that repair/replacement can be arranged.
3. Patient agrees to provide us access to our rental equipment for repair/replacement, maintenance, and or pick-up of the equipment.
4. Patient agrees to use the equipment for the purposes so indicated and in compliance with the physician's prescription.
5. Patient agrees to keep the equipment in their possession and at the address, to which it was delivered unless otherwise authorized.
6. Patient agrees to notify us of any hospitalization, change in customer insurance, address, telephone number, physician, or when the medical need for the rental equipment no longer exists.
7. Patient agrees to request payment of authorized Medicare, Medicaid or other private insurance benefits are paid directly to us for any services we furnish.
8. Patient agrees to accept all financial responsibility for home medical equipment furnished by us.
9. Patient agrees to pay for the replacement cost of any equipment damaged, destroyed, or lost due to misuse, abuse or neglect.
10. Patient agrees not to modify the rental equipment without the prior consent.
11. Patient agrees that any authorized modification shall belong to the titleholder of the equipment unless equipment is purchased and paid for in full.
12. Patient agrees that we retain title to the rental equipment and all parts unless equipment is purchased and paid for in full.
13. Patient agrees that our company shall not insure or be responsible to the patient for any personal injury or property damage related to any equipment, including that caused by use or improper functioning of the equipment, the act or omission of any other third party, or by any criminal act or activity, war, riot, insurrection, fire or act of God.
14. Patient understands that we retain the right to refuse delivery of service to any patient at any time.
15. Patient agrees that any legal fees resulting from a disagreement between the parties shall be borne by the unsuccessful party in any legal action taken.
INFECTION CONTROL AT HOME

Preventing infections helps protect you, your family and friends, caregivers, health care providers and the community from infections. Properly performing the following activities will help reduce the risk of infection:

- Hand washing
- Handling, cleaning, storage and disposal of used equipment and supplies
- Housekeeping/laundry
- Food preparation

Some illnesses and treatments (such as chemotherapy, dialysis, AIDS, diabetes and burns) can make people more at risk for infection. Your nurse will tell you how to take precautions such as using gloves, gowns, masks, etc., if you need it.

Be sure to tell your physicians and home care staff member if you notice any of the following signs and symptoms of infection:

- Fevers or chills
- Nausea, vomiting or diarrhea
- Pain, tenderness, redness or swelling
- Inflamed skin, rash, sores or ulcer
- Increased tiredness or weakness
- Confusion
- Green or yellow pus

WASH YOUR HANDS

Hand washing is the single most important step in controlling the spread of infection.

Proper hand washing is important and should be done thoroughly and frequently, especially during cold and flu season.

- Wet hands and apply soap (liquid soap is best).
- Rub hands together for at least 20 seconds and be sure to wash all surfaces including wrists, palms, back of hands, between fingers and under your nails.
- Rinse hands and pat dry using a paper towel or a clean towel that is not shared with others. Turn off faucet with paper towel.

Always wash hands before:

- Treating a cut or wound
- Handling medical equipment or supplies
- Eating or preparing food
- Taking or administering medication
- Caring for a sick person

Always wash hands after:

- Caring for a sick person
- Treating a cut or wound
- Using the bathroom
- Coughing, sneezing or blowing your nose
- Handling soiled laundry, towels or linens
- Cleaning bathrooms, floors, etc.
- Touching raw meats, fish, or eggs
- Touching garbage
- Changing diapers
- Touching animals or their waste
- Whenever hands become soiled
MEDICAL SUPPLIES AND EQUIPMENT

Properly storing, handling, cleaning and disposal of medical equipment and supplies are an important part of infection control.

Be sure to store all medical equipment and supplies so that they do not become dirty or damaged and are not accessible to children or pets. Be sure to follow manufacturer's instructions for proper cleaning and storage of reusable equipment and supplies.

Disposable equipment and supplies:

- If equipment or supply is not sharp (bandages, tissues, gloves, diapers, etc.), place item in a plastic bag, seal, and then discard in the trash.
- If the item is sharp and can cut or puncture someone (lancets, syringes, razors, needles, etc.), be sure to dispose of carefully.
  - Place sharp items in a heavy gauge, hard plastic container, with a screw-top lid immediately after use. A liquid laundry detergent bottle works well. Glass, cardboard or thin plastic containers such as milk cartons should not be used.
  - Do not over fill the container,
  - Be sure that the disposal container is not recycled or returned to a store.
  - Seal container and dispose of in the trash or according to area regulation.

Re-usable equipment and supplies:

- Clean and/or disinfect items according to manufacturer instructions or as directed by your health care or equipment supplier.
- Items should be cleaned and/or disinfected immediately after use or as directed by your health care or equipment supplier.
- Household items such as dishes should be washed in hot, soapy water or dishwasher.
- Personal use items such as clothing towels and bed linens should be washed in hot, soapy water or according to manufacturer's instructions.
- Household and/or personal use items of persons who are ill or at risk of infection should be washed/laundered separately.

HOUSEHOLD SURFACES

Routine cleaning of household surfaces helps reduce the risk/amount of germs, dirt, infestations (ants, roaches, fleas) and dust in the home:

- Household surfaces such as tub/shower areas, toilets, counters, hard surfaces floors, etc., should be cleaned regularly using normal household cleaning products. Be sure to read all product instructions and never mix household cleaning products.
- Carpets and upholstered furnishings should be vacuumed regularly.
- If a hard surface becomes soiled with blood/body fluid:
  - Put on disposable gloves.
  - Wipe area with paper towels.
  - Clean area with a household disinfectant and follow product instructions or a solution of 1 cup bleach to
  - 10 cups water can be used to clean the area. Be sure not to mix bleach with other cleaning products.
  - Be sure the type of disinfectant you choose is appropriate and will not damage the surface.
  - Place all disposable items used in a plastic bag and seal, place in another plastic bag then seal and place in the trash.
- Wash hands.
• If a soft surface such as carpeting or furniture becomes soiled with blood/body fluid:
  ▪ Put on disposable gloves.
  ▪ Blot area with paper towels and discard in plastic bag.
  ▪ Clean area with a disinfectant/cleaner approved for the item soiled and follow product instructions.
  ▪ Place all disposable items used in a plastic bag and seal, place in another plastic bag then seal and place in the trash.
  ▪ Wash hands
  ▪ Note: Cleaning products such as bleach can damage/discolor soft surfaces. Consult a professional cleaner if you need assistance with cleaning an upholstered item or carpeting.

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<th>FLU (INFLUENZA) PRECAUTIONS</th>
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<td>There are many things that you can do to keep from getting sick from colds, flu and many other viruses:</td>
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<tr>
<td>• Wash your hands often with soap and water.</td>
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<tr>
<td>• Remind caregivers, family members and visitors to wash their hands.</td>
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<tr>
<td>• When you sneeze or cough:</td>
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<tr>
<td>▪ Cover your nose and mouth with a tissue, discard tissue in the trash, then immediately wash your hands.</td>
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<tr>
<td>▪ Use your upper sleeve to cough/sneeze into if you do not have a tissue.</td>
</tr>
<tr>
<td>▪ Wash hands immediately after coughing, sneezing or blowing your nose.</td>
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<tr>
<td>• Avoid touching your eyes, nose or mouth.</td>
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<tr>
<td>• Ask that friends and family not visit if they are not feeling well.</td>
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<tr>
<td>• Avoid contact with sick persons.</td>
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<tr>
<td>• Obtain all physician recommended vaccines.</td>
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<tr>
<td>• Your physician or nurse may provide additional instructions as appropriate to the situation such as wearing a mask.</td>
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<tr>
<th>FOOD PREPARATION AND HANDLING</th>
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<tr>
<td><em>Infections can spread easily when food is improperly prepared or served.</em></td>
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<tr>
<td><strong>To prepare food safely:</strong></td>
</tr>
<tr>
<td>• Wash your hands before handling any food.</td>
</tr>
<tr>
<td>• Handle raw meat, poultry and eggs with extra care and wash hands and surfaces after touching.</td>
</tr>
<tr>
<td>• Wash fruits and vegetables thoroughly.</td>
</tr>
<tr>
<td>• Cook all food at high enough temperatures, and for a long enough time, to kill harmful microorganisms.</td>
</tr>
<tr>
<td>• Use separate cutting boards and knives for different types of foods (for example, raw meats versus ready-to-eat foods, such as fruits and vegetables).</td>
</tr>
<tr>
<td><strong>To serve food safely:</strong></td>
</tr>
<tr>
<td>• Wash hands before serving any food and after picking up used utensils, glasses, plates, etc.</td>
</tr>
<tr>
<td>• Keep food covered until it's served.</td>
</tr>
<tr>
<td>• Keep cold and hot foods at the appropriate temperatures.</td>
</tr>
<tr>
<td>• Always pick up utensils by the handles.</td>
</tr>
</tbody>
</table>
Health care facilities providing services in which there is a risk of skin, eye, mucous membrane, or parenteral contact to human blood or other potentially infectious materials must practice universal precautions.

Universal Precautions means the prevention of disease transmission through the use of infection control practices with all the patients.

Our company complies with the infection control practices required by Indiana State Department of Health (ISDH), which were adopted by Indiana law, Indiana Occupational Safety and Health Administration (IOSHA) standards and Centers for Disease Control and Prevention (DCD) recommendations. The following infection control practices include, but are not limited to, those required by the Universal Precautions Rule and are used to prevent transmission of bloodborne pathogens to patients and treating staff:

- Appropriate use of protective barriers, including gloves for hand contact, masks, gowns, laboratory coats, and protective eyewear or face shields are used for procedures having the potential of creating a spray or splatter of blood or other potentially infectious materials.
- Gloves, when required, are changed and hands are washed after each patient.
- Heat stable, nondisposable instruments requiring sterilization that are contaminated with blood or other potentially infectious materials are heat sterilized after treatment of each patient.
- Precautions are taken to prevent injuries caused by needles, syringes and other contaminated sharp objects are discarded in puncture-resistant containers.
- Surfaces and equipment contaminated with blood or other potentially infectious materials that need not be sterilized are cleaned and disinfected after treatment of each patient. Disposable coverings may be used on some surfaces to prevent contamination.
- Infectious waste is placed in containers labeled with the biohazard symbol, impervious to moisture and of sufficient strength to prevent expulsion.
- Containers of infectious waste are stored in a secure area prior to treatment and final disposal.
- Patient care staff receive training on infection control.

The infection control procedures listed, and others that are not readily observable, protect you from disease transmission. Indiana law requires that health care facilities commitment should be brought to the attention of Chief Clinical Officer at 1-800-875-2622 at this facility. If you are not satisfied with the explanation of Universal Precautions provided by this facility, you may file an official complaint with the Indiana State Department of Health by writing to the following address:

Indiana State Department of Health
C/O Universal Precautions Coordinator
2 North Meridian St., Indianapolis, IN 46206
(317) 234-2804
Statement of Advance Directive of Living Wills

Under Federal law, every adult has the right to make certain decisions concerning his or her medical treatment. The law also allows for your rights and personal wishes to be respected even if you are too sick to make decisions yourself.

You have the right, under certain conditions, to decide whether to accept or reject medical treatment, including whether to continue medical treatment and other procedures that would prolong your life artificially.

You may spell out these rights in a “living will”, containing your personal directions about life-prolonging treatment in the case of serious illness that could cause death.

You may also designate another person, or surrogate, who may make decisions for you if you become or physically unable to do so. This surrogate may function on your behalf for a brief time or longer, for a life threatening or a non-life-threatening illness.

Any limits to the power of the surrogate in making decisions for you should be clearly expressed. It is advisable to name a replacement in case the person you have chosen to make decisions for you becomes unable or unwilling to do so.

If you decide to make a living will or other advance directive, it is recommended that you give a copy to your doctor, your closest relative or friend and any hospital, nursing home or other facility where you are receiving treatment or care. If you change your mind, make sure that you so advise all those to whom you have given copies.

A living will in no way affects life insurance. Also, it cannot be required as a condition for being insured or receiving health care services. Any medical treatment used for providing comfort care or to alleviate pain will be continued. A summary like this cannot answer all of your questions or cover every circumstance. If you have questions about your particular legal situation, please talk to a lawyer. Also, talk to your health care provider about the medical issues. Let those who will be caring for you know what you have decided.
Notice of Privacy Practices

Effective 4/2003; Revised 8/2013

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

If you have any questions about this notice, please contact the Chief Clinical Officer, Judy Schuler at 1-800-875-2622

Definitions

Notice of Privacy Practices (The Notice) – a written notice in compliance with the requirements of Health Insurance Portability and Accountability Act (HIPAA), and the Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act (ARRA) of 2009, made available from your Home Health Agency to you or your personal representative at the first delivery of service, or at your next visit following a revision to the Notice, that describes the uses and disclosures of protected health information that may be made by your Home Health Agency and your rights and the Home Health Agency’s legal duties with respect to protected health information.

Protected Health Information (PHI) – individually identifiable health information that is transmitted or maintained in any form or medium, including electronic media. Protected health information does not include employment records held by your Home Health Agency in its role as an employer.

Your Home Health Agency, an affiliate member of Catholic Health Initiatives (CHI), and other affiliated members of CHI participate in an Organized Health Care Arrangement (OHCA) in order to share health information to manage joint operational activities. A complete list of CHI affiliated members is available at www.catholichealthinitiatives.org by clicking on “Locations”. A paper copy is available upon request. The CHI OHCA may use and disclose your health information to provide treatment, payment, or health care operations for the affiliated members such as integrated information system management, health information exchange, financial and billing services, insurance, quality improvement, and risk management activities.

Your Home Health Agency may use and disclose your health information to provide treatment, payment, or health care operations for the affiliated members such as integrated information system management, health information exchange, financial and billing services, insurance, quality improvement, and risk management activities.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

For Treatment. We will use your health information to provide you with health care treatment and to coordinate or manage services with other health care providers, including third parties. We may disclose all or any portion of your health information to your attending physician, consulting physician(s), nurses, technicians, health profession students, or other facility or health care personnel who have a legitimate need for such information in order to take care of you. We may disclose your health information to family members or friends, guardians or personal representatives who are involved with your health care. We may also use and disclose your health information to contact you for appointment reminders and to provide you with information about possible treatment options or alternatives and other health-related benefits and services. We also may disclose your health
information to people outside the facility who may be involved in your health care after you leave the facility, such as other physicians involved in your care, specialty hospitals, skilled nursing care facilities, and other healthcare-related services. We may use and disclose your health information to prescription networks to obtain your prescription benefits from payers, to obtain your medication history from different health care providers in the community such as pharmacies, and to send your prescriptions electronically to your pharmacy.

For Payment. We will use and disclose your health information for activities that are necessary to receive payment for our services, such as determining insurance coverage, billing, payment and collection, claims management, and medical data processing. For example, we may tell your health plan about a treatment you are planning in order to receive approval or to determine whether your plan will pay for the proposed treatment. We may disclose your health information to other health care providers so they can receive payment for health care services that they provided to you, such as your personal physician, and other physicians involved in your health care such as an emergency physician, and ambulance services. We may also give information to other third parties or individuals who are responsible for payment for your health care, such as the named insured under the health policy who will receive an explanation of benefits (EOB) for all beneficiaries who are covered under the insured’s plan.

For Health Care Operations. We may use and disclose your health information for routine facility operations, such as business planning and development, quality review of services provided, internal auditing, accreditation, certification, licensing or credentialing activities (including the licensing or credentialing activities of health care professionals), medical research and education for staff and students, assessing your satisfaction with our services, and to other healthcare entities that have a relationship with you and need the information for operational purposes. We may use and disclose your health information to the external agencies responsible for oversight of health care activities such as The Joint Commission, external quality assurance and peer review organizations, and credentialing organizations. We may also disclose health information to business associates we have contracted with to perform services for or on our behalf such as patient satisfaction survey organizations. We may also disclose your health information to medical device manufacturers or pharmaceutical companies in order for those companies to carry out their legal obligations to state and federal agencies.

Future Communications. We may provide communications to you with newsletters or other means regarding treatment options, health related information, disease management programs, wellness programs, or other community based initiatives or activities in which your Home Health Agency is participating.

Fundraising Activities. We may use your health information, or disclose your health information to a foundation related to us for the Home Health Agency’s fundraising efforts. These funds would be used to expand and improve services and programs we provide to the community. We would only release information such as your name, address, other contact information, age, gender, dates of birth, health insurance status, the dates you received treatment or services from us, the department of service and the outcome of those services. You have a right to opt out of receiving such communications. To opt out of these communications, contact the Chief Clinical Officer, Judy Schuler at 800-875-2622 or mail to 1700 Edison Drive, Milford, OH 45150.

Research. We may use and disclose your health information to researchers either when you authorize the use and disclosure of your health information, or your Home Health Agency’s Institutional Review Board and/or Privacy Board approves an authorization waiver for the use and disclosure of your health information for a research study.

Organ and Tissue Donation. If you are an organ donor, we may release your health information to organizations that handle organ procurement and transplantation or to an organ donation bank as necessary to facilitate organ or tissue donation and transplantation.
USES AND DISCLOSURES THAT ARE REQUIRED OR PERMITTED BY LAW

Subject to requirements of federal, state and local laws, we are either required or permitted to report your health information for various purposes. Some of these reporting requirements and permissions include:

Public Health Activities. We may disclose your health information to public health officials for activities such as for the prevention or control of communicable disease, bioterrorism, injury, or disability; to report births and deaths; to report suspected child, elder, or spouse abuse or neglect; to report reactions to medications or problems with medical products; to report information to the federal Centers for Disease Control or to authorized national or state cancer registries for their data aggregation.

Disaster Relief Efforts. We may disclose your health information to an entity assisting in a disaster relief effort, such as the American Red Cross, so that your family can be notified about your condition and location.

Health Oversight Activities. We may disclose your health information to a health oversight agency for activities authorized by law. Such agencies include federal Centers for Medicare and Medicaid Services, and state medical or nursing boards. These oversight activities may include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor activities such as health care treatment and spending, government programs, and compliance with civil rights laws.

Judicial or Administrative Proceeding. We may disclose your health information in response to a legal court or administrative order, a subpoena, discovery request, civil or criminal proceedings, or other lawful process.

Law Enforcement. We may release your health information if asked to do so by a law enforcement official or if we have a legal obligation to notify the appropriate law enforcement or other agencies:
- In response to a court order, subpoena, warrant, summons or similar legal process;
- Regarding a victim or death of a victim of a crime in limited circumstances;
- In emergency circumstances to report a crime, the location or victims of a crime, or the identity, description or location of a person who is alleged to have committed a crime, including crimes that may occur at our facility, such as theft, drug diversion, or attempts to obtain drugs illegally.

Coroners, Medical Examiners and Funeral Directors. We may release health information to a coroner or a medical examiner. This may be necessary to identify a person who died or to determine the cause of death. We may release health information to help a funeral director to carry out his/her duties.

Workers' Compensation. We may release your health information for workers’ compensation benefits or similar programs that provide benefits for work-related injuries or illnesses if you tell us that workers’ compensation is the payer for your visit(s). Your employer or their workers’ compensation carrier may request the entire medical record pertinent to your workers’ compensation claim. This medical record may include details regarding your health history, current medications you are taking, and treatments.

To Avert a Serious Threat to Health or Safety. We may disclose your health information when necessary to prevent a serious threat to your health and safety or the health and safety of another person or the public.

National Security. We may disclose your health information to federal official(s) for national security activities and for the protection of the President and other Heads of State.
Military and Veterans. If you are a member of the armed forces, we may release your health information as required by military command authorities. We may also release health information about foreign military personnel to the appropriate foreign military authority.

Inmates. If you are an inmate of a correctional institution or in the custody of a law enforcement official, we may release your health information to the institution or law enforcement official. This release would be necessary for the institution to provide you with health care, to protect your health and safety or the health and safety of others, or for the safety and security of the correctional institution.

OTHER USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

Other uses and disclosures of your health information not covered by this notice or the laws that apply to your Home Health Agency will be made only with your written authorization. If you provide us with authorization to use or disclose your health information, you may revoke that authorization in writing at any time. When we receive your written revocation we will no longer use or disclose your health information for the purpose of that authorization. However, we are unable to retrieve any disclosures already made based on your prior authorization.

Your Home Health Agency will obtain your authorization to use and disclose your health information for these specific purposes:

Marketing
Your Home Health Agency may ask you to authorize us to use and disclose your health information for marketing purposes. Marketing is a communication about a product or service that you may be interested in purchasing. If your Home Health Agency receives payment of any kind from a third party in order for your Home Health Agency to promote the product or service to you, then your Home Health Agency is required to obtain your written authorization before we can use or disclose your health information. Your Home Health Agency is not required to obtain your authorization to discuss with you about your Home Health Agency health-related products or services that are available for your health care treatment, case management or care coordination, or to direct or recommend alternative treatments, therapies, providers, or settings of care, providing face to face discussions and offering samples or promotional gifts of nominal value.

You have the right to revoke your marketing authorization and your Home Health Agency will honor the revocation. To opt out of these communications, please contact the Chief Clinical Officer, Judy Schuler at 1700 Edison Drive, Milford, OH 45157 or 1-800875-2622.

Psychotherapy notes. Psychotherapy notes are notes by a mental health professional that document or analyze the contents of a conversation during a private counseling session or a group, joint, or family counseling session. If psychotherapy notes are maintained separate from the rest of your health information they may not be used or disclosed without your written authorization, except as may be required by law.

Sale of PHI
Your Home Health Agency will obtain your authorization for any disclosure of your information which your Home Health Agency directly or indirectly receives remuneration in exchange for the information.
YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the following rights regarding your health information:

**Right to Inspect and Copy.** You have the right to inspect your health information and receive a copy of medical, billing, or other records that may be used to make decisions about your care. The right to inspect and receive a copy may not apply to psychotherapy notes that are maintained separately from your health information.

Your request to inspect and receive a copy of your health information must be submitted in writing. We may charge a fee for document requests to cover the costs of copying, mailing, or other supplies. You have the right to request your health information in electronic format. Your Home Health Agency will provide your health information in the form and format you request, if available or in a mutually agreeable form and format.

In limited circumstances we may deny your request to inspect or receive a copy of your health information. If you are denied access to your health information, you may request that the denial be reviewed. A licensed health care professional chosen by your Home Health Agency will review your request and the denial. The person who conducts the review will not be the same person who denied your request. We will comply with the outcome of the review.

**Right to Amend.** You have the right to request an amendment to your health information that you believe is incorrect or incomplete.

Submit your request in writing, including your reason for the amendment, using our “Request for Amendment to PHI” and send to the Chief Clinical Officer, Judy Schuler at 1700 Edison Drive, Milford, OH 45150. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. We may also deny your request if you ask us to amend information that:

- Was not created by your Home Health Agency unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for your Home Care;
- Is not part of the information that you would be permitted to inspect and copy; or
- Is accurate and complete.

**Right to an Accounting of Disclosures.** We are required to maintain a list of disclosures of your health information. However, we are not required to maintain a list of disclosures that we made by acting upon your written authorizations. You have the right to request an accounting of disclosures that are not subject to your written authorization.

Submit your request in writing using our “Request for Accounting of Disclosures of PHI” form and send to the Chief Clinical Officer, Judy Schuler at 1700 Edison Drive, Milford, OH 45150. Your request must state a time period, not longer than six years from the date of request. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request before any costs are incurred.

**Right to Request Restrictions.** You have the right to request a restriction or limitation on how much of your health information we use or disclose for treatment, payment, or health care operations. You also have the right to request a restriction on the disclosure of your health information to someone who is involved in your care or payment for your care, such as a family member or friend.

*We are not required to agree to your request.* However, if we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.
You have the right to request to restrict the disclosure of your information to a health plan regarding a specific health care item or service that you, or someone on your behalf (other than a health plan), has paid for in full. We are required to comply with your request for this specific type of restriction. For example, if you sought counseling services and paid in full for the services rather than submitting the expenses to a health plan, you may request that your health information related to the counseling services not be disclosed to your health plan.

Submit your request in writing or request and submit a “Request for Restrictions to Use or Disclose Protected Health Information” form and send to the Chief Clinical Officer, Judy Schuler at 1700 Edison Drive, Milford, OH 45150. You must include: a description of the information that you want to restrict, whether you want to restrict our use or disclosure or both; and to whom you want the restriction to apply.

**Right to Request Confidential Communications.** You have the right to request that we communicate with you about health care matters in a certain way or at a certain location. For example, you can ask that we only contact you at an alternative location from your home address, such as work, or only contact you by mail instead of by phone. Your request must specify how or where you wish to be contacted. We do not require a reason for the request. We will accommodate all reasonable requests.

**Right to Receive Notice of a Privacy Breach.** You have the right to receive written notification if your Home Health Agency discovers your health information was inappropriately used or disclosed.

**Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. If you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

To obtain an additional paper copy of this notice, contact the Chief Clinical Officer, Judy Schuler at 1700 Edison Drive, Milford, OH 45150 or call 1-800-875-2622. Or, you may obtain a copy of this notice at our Web site, [http://www.consolidatedhealthservices.com/](http://www.consolidatedhealthservices.com/).

**CHANGES TO THIS NOTICE**

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you and for any information we may receive in the future. We will post a copy of the current notice in the facility (if applicable) and on our web site, [http://www.consolidatedhealthservices.com/](http://www.consolidatedhealthservices.com/). The notice will contain the effective date. Upon your initial registration or admittance to the facility for treatment or health care services as an inpatient or outpatient, we will offer you a copy of the notice currently in effect. Whenever the notice is revised, it will be available to you upon request.

**COMPLAINTS**

You may file a complaint with us or with the Secretary of the Department of Health and Human Services if you believe that we have not complied with our privacy practices.

You may file a complaint with us by contacting the Clinical Optimization Department at Consolidated Health Services, Attn: Chief Clinical Officer, 1700 Edison Drive, Milford, OH 45157 or calling 1-800-875-2622. If you file a complaint, we will not take any action against you or change our treatment of you in any way.
Medicare DMEPOS Supplier Statement

The products and/or services provided to you by supplier legal business name or DBA are subject to the supplier standards contained in the Federal regulations shown at 42 Code of Federal Regulations Section 424.57(c). These standards concern business professional and operational matters (e.g., honoring warranties and hours of operation). The full text of these standards can be obtained at [http://ecfr.gpoaccess.gov](http://ecfr.gpoaccess.gov). Upon request we will furnish you a written copy of the standards.

RETURN POLICY

- Substandard or unsuitable items may be returned.
- Customized or special ordered items may NOT be returned except in the case of defect
- All returns require a copy of receipt (Delivery Ticket) and must be done within 10 days of sale. Certain physician prescribed items (CPAP machines for example) may require a physician order to return the item.
- Rental equipment can only be returned (picked up) if:
  - Equipment is no longer needed for medical reasons or your physician discontinues the equipment (pertains to items such as aerosol, oxygen, CPAP and Bilevel).
  - You are admitted to a Skilled Nursing Facility.
  - You are admitted to a hospital for 30 days or more.
  - You sign an AMA form (Against Medical Advise) if your physician wants you to keep using the equipment.
  - You are moving outside our service area. We will make every attempt to refer you to another company serving the area that you are moving to.
  - You wish to use another home care dealer if your insurance provider contract authorizes or requires.

Please note that rental equipment is billed in whole month increments, based upon the date you received it, and will not be prorated. The return of rental equipment will not eliminate or reduce the financial responsibility for the months you rented the equipment.

WARRANTY INFORMATION

Every product sold or rented by our company carries a minimum 1 year manufacturer’s warranty. We will notify all Medicare beneficiaries of the warranty coverage, and we will honor all warranties under applicable law.

We will repair or replace, free of charge, Medicare covered equipment that is under warranty. In addition, an owner’s manual with warranty information will be provided to beneficiaries for all durable medical equipment where this manual is available.
IF YOU HAVE A COMPLAINT

We make every effort to provide you with the best possible service. However on occasion problems do occur.

The patient has the right to freely voice grievances and recommend changes in care or services without fear of reprisal or unreasonable interruptions of services. Service, equipment, and billing complaints will be communicated to management and upper management. These complaints will be documented in the Medicare Beneficiaries Complaint Log, and completed forms will include your name, address, telephone number, and health insurance claim number, a summary of the complaint, the date it was received, the name of the person receiving the complaint, and summary of actions taken to resolve the complaint. All complaints will be handled in a professional manner. All logged complaints will be investigated, acted upon, and responded to in writing or by telephone by a manager within a reasonable amount of time after the receipt of the complaint. If there is no satisfactory resolution of the complaint, the next level of management will be notified progressively and up to the president or owner of the company. You will be informed of this complaint resolution protocol at the time of the set-up of service.

We are accredited by CHAP and JCAHO. Should you have a problem, CHAP/JCAHO provides an efficient complaint and investigation process for all of its accredited agencies, in addition to state and federal processes. CHAP promises a prompt response to your concerns (1-800-656-9656 x203). Office hours are from 8:00 am - 5:00 pm Eastern Standard Time. JCAHO promises a prompt response to your concerns. Office hours are from 8:00 am - 5:00 pm Eastern Standard Time. (630-792-5800).

POLICY

We make available to all clients the toll-free hotline that has been activated by the United States Department of Health and Human Services. The toll free hotline is 1-800-HHS-TIPS (1-800-447-8477) and accepts calls concerning alleged fraud against Medicare and Medicaid programs.

WHERE TO CALL

For routine questions regarding orders, billing, etc., please call us between 8:00 am and 4:30 pm, Monday through Friday. We also provide customer service 24 hours a day, 7 days a week, through an emergency response system for equipment problems. The local telephone numbers and/or the toll free numbers to call will be provided by the your Representative upon their first visit.
Below is an example of a Patient Satisfaction Survey you may be receiving from us. If you should receive a survey, we greatly appreciate your time and input by answering the questions with the highest score of 10. Our surveys typically are done via telephone however you are able to complete one via internet if an email is provided. We welcome you to call our local office to provide us with an email address.

Thank you for your recent equipment order. We know you have a choice in equipment supply providers, and we appreciate the trust you have placed in us.

We want to ensure that your ordering experience met or exceeded your expectations. We are contacting you to conduct a very brief satisfaction survey. Providing feedback in this survey will help us to improve our service to you. We strive for the highest score of 10.

To take the survey, please click on the button below.

Take the Survey

Please rate the following questions on a scale of 1 to 10 with 10 being the most satisfied.

1. Was your delivery made in a timely manner?
2. Were you instructed on how to safely operate the equipment?
3. Your comfort in using and maintaining the equipment?
4. Staff knowledge and courteousness?
5. Instruction for after-hours emergency provider contact?
6. Overall service rating?
7. How likely are you to recommend this service?

Thank you for your time in completing this questionnaire, your feedback is important to us. We will continue to strive to provide quality services for our patients.
**Client Communication**

We genuinely strive to provide the highest quality services for our clients. That is why your concerns are our concerns. To ensure that our service meets your total satisfaction, we ask you to describe completely any problem or concern you may have. Additionally, if you wish to compliment one of our associates, please feel free to do so by using this form.

This completed form will be routed directly to the Chief Clinical Officer who will promptly review this concern and make verbal or written communications with you as necessary to assure you that the problem has or is being corrected.

We appreciate your candid comments as well as your assistance in helping us to continually improve our service to our many and valued customers.

CLIENT’S NAME: __________________________________________

INITIAL DATE OF CONCERN: ____________________ TODAY’S DATE:_____________________ 

ASSOCIATE’S NAME (If applicable): __________________________________________

DESCREIBE YOUR ☐ CONCERN ☐ COMPLIMENT: ________________________________________

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Would you like to be contacted by management to discuss your concern? ☐ Yes ☐ No

Your name: __________________________________________ ☐ Client ☐ Caregiver

Phone number: ____________________________________
ACKNOWLEDGEMENT OF YOUR COMPANY’S SET UP BOOKLET AND INFORMATION

I acknowledge that I received your company’s Setup Booklet and had the opportunity to ask questions.

Your company’s Setup Booklet contains:

- [ ] Photo Identification Viewed
- [ ] Proof of Delivery of Home Medical Equipment
- [ ] Mission Statement, Core Values, Vision
- [ ] Basic Home Safety Guidelines
- [ ] Patient Bill of Rights & Responsibilities
- [ ] Statement of Advance Directive of Living Will
- [ ] Notice of Privacy Practices
- [ ] Emergency Planning
- [ ] Medicare Supplier Standards
- [ ] Satisfaction Survey
- [ ] Return Policy
- [ ] If you have a Complaint
- [ ] Service Hours of Operation
- [ ] 24 Hour Emergency Number
- [ ] Equipment Instruction Sheets
- [ ] Plan of Service Completed
- [ ] Community Resources Reviewed
- [ ] Warranty Information Reviewed

- [ ] Explanation of Charges

Our Company may not be able to verify benefits prior to delivery of the home medical equipment. Contact our company for verification of benefits. Hours: 8:00am – 4:30 pm Monday – Friday, or contact the insurance carrier via website or benefits phone number located on the back of insurance card.

Financial Responsibility

I agree to pay and guarantee payment in full of any and all charges for services and home medical equipment provided by your company. I agree to pay and guarantee payment of all coinsurance, deductions and co-payments, and charges not covered by insurance.

Release of Your Health Information

I acknowledge that your company may disclose my health information as explained in the Notice of Privacy Practices to carry out treatment, payment, and health care operations. I acknowledge that my health information may be received or disclose by various means including, telephone, mail, electronic mail, and facsimile.

I authorize your company to share my health information with the following person(s) who are involved with my care:

Name: ________________________________ Relationship: ________________ Ph: ______________
Name: ________________________________ Relationship: ________________ Ph: ______________
Name: ________________________________ Relationship: ________________ Ph: ______________

REPRESENTATION AND SIGNATURE

My signature below indicates that I have read fully and understand the information listed above and have my questions answered fully. I hereby accept and agree to the terms set forth in this agreement.

Patient/Guardian/Guarantor

Signature: __________________________________________ Date: __________________________

(If signed by anyone other than the patient, please complete the following information)

Name: ________________________________ Relationship: __________________________
Address: ________________________________ Reason patient did not sign: __________________________
## PLAN OF SERVICE

<table>
<thead>
<tr>
<th>Patient:</th>
<th>Emergency Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>Phone number:</td>
</tr>
<tr>
<td>Phone number:</td>
<td>Agency:</td>
</tr>
<tr>
<td>PCP:</td>
<td></td>
</tr>
<tr>
<td>Primary Diagnosis:</td>
<td>Allergies/Infectious Disease: □ N/K □ Other (Specify)</td>
</tr>
<tr>
<td>Secondary Diagnosis:</td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
</tr>
</tbody>
</table>

### Functional Limitations:
- □ Patient
- □ Caregiver
- Independently manages all tasks related to equipment
- □ If equipment is setup by someone else, the patient is able to manage all other aspects of equipment
- □ Requires considerable assistance to manage equipment, but independently completes portions of the task
- □ Is only able to monitor equipment and must depend on someone else to manage equipment
- □ Completely dependent on someone else to manage all aspects of the equipment

### Activities Permitted:
- □ No Restriction
- □ Ambulatory with Aid
- □ Wheelchair Bound
- □ Bed Bound

### Learning Assessment:
- □ Patient
- □ Caregiver
- is able to understand instructions on equipment
- □ Yes
- □ No

### Family/Caregiver Support:
- □ Patient is independent
- □ Patient lives alone with family/caregiver available for support
- □ Patient lives alone and needs support

### Environmental Assessment:
- □ Yes
- □ No
  - Working smoke alarm (if no, pt advised)
  - Adequate space for equipment
  - Patient advised of electrical requirements
  - Adaptor provided
  - Clean environment
  - Tripping hazards (if yes, pt advised)

### Objective: To demonstrate an understanding of:
- □ Yes
- □ No
  - Physician orders
  - Function and purpose of equipment
  - Cleaning maintaining the equipment
  - Using Patient instruction sheet(s)
  - Client/Caregiver has demonstrated all of the above via return demonstration to ensure understanding

### Equipment:

### Other Problem or Need (specify):

### Goal: □ Patient □ Caregiver will be knowledgeable in the safe operation, maintenance, cleaning, disinfection, and troubleshooting of delivered equipment. Ensure understanding of the prescribing physician’s intended use of the equipment.

### Services / Actions: □ Patient □ Caregiver received the equipment and instructions per company policies and procedures with successful return demonstration. The equipment will be maintained according to company policy and procedures. Equipment provided is appropriate for the client’s needs and medical condition.

### Other Comments:

### Next Contact:
- □ None
- □ 3 Months
- □ 6 Months
- □ As Needed

### Method: □ Phone □ Visit

### Employee: Date

### Operations Review: Date:
Medicare Capped Rental and Inexpensive or Routinely Purchased Items Notification for Services on or after January 1, 2006

I received instructions and understand that Medicare defines the ______________________________ that I received as being either a capped rental or an inexpensive or routinely purchased item.

_____ FOR CAPPED RENTAL ITEMS:

- Medicare will pay a monthly rental fee for a period not to exceed 13 months, after which ownership of the equipment is transferred to the Medicare beneficiary.
- After ownership of the equipment is transferred to the Medicare beneficiary, it is the beneficiary’s responsibility to arrange for any required equipment service or repair.
- Examples of this type of equipment include: Hospital beds, wheelchairs, alternating pressure pads, air-fluidized beds, nebulizers, suction pumps, continuous airway pressure (CPAP) devices, patient lifts, and trapeze bars.

_____ FOR INEXPENSIVE OR ROUTINELY PURCHASED ITEMS:

- Equipment in this category can be purchased or rented; however, the total amount paid for monthly rentals cannot exceed the fee schedule purchase amount.
- Examples of this type of equipment include: Canes, walkers, crutches, commode chairs, low pressure and positioning equalization pads, home blood glucose monitors, seat lift mechanisms, pneumatic compressors (lymphedema pumps), bed side rails, and traction equipment.
- I select the:
  Purchase Option _____________ Rental Option _____________

_____________________________________________ __________________________
Patient Signature        Date
Every product sold or rented by our company carries a 1-year manufacturer's warranty. Cornerstone Medical Services and the family of companies will notify all Medicare beneficiaries of the warranty coverage, and we will honor all warranties under applicable law. Cornerstone Medical Services and the family of companies will repair or replace, free of charge, Medicare-covered equipment that is under warranty. In addition, an owner's manual with warranty information will be provided to beneficiaries for all durable medical equipment where this manual is available.

I have been instructed and understand the warranty coverage on the product I have received.

_____________________________________    _____________________________
Patient Signature       Date
<table>
<thead>
<tr>
<th><strong>INSURANCE INFORMATION</strong></th>
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<tbody>
<tr>
<td><strong>Patient Name:</strong></td>
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<tr>
<td><strong>Primary Insurance</strong></td>
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<tr>
<td>Insurance Name:</td>
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<td></td>
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<td>Phone number:</td>
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<tr>
<td>Insured Name:</td>
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<tr>
<td>Employer:</td>
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</tbody>
</table>
Credit/Debit Card Authorization and Electronic Funds Transfer (EFT) Form

Patient Name: __________________________________________ Patient ID # ________________
Cardholder/Bank Acct. Owner Name: _____________________________________________________
Cardholder/Bank Acct. Owner Address: ___________________________________________________
_________________________________________________________________________________
City      State   Zip Code

Select One Payment Option:

Credit Card:        Master Card   Visa   Discover   American Express
Card Number: ______________________________________________________________
Expiration Date: ____________________________________________________________

Check and complete one below:
☐ I authorize $ __________ to be charged to my card one time only.
☐ I authorize $ __________ to be charged monthly for as long as the equipment is on rent.
☐ I authorize $ __________ to be charged each month until my balance is paid in full.
☐ I authorize all charged if other than anniversary date ______________________________
Date credit card is to be charged if other than anniversary date ______________________________

Electronic Funds Transfer (EFT):

Name of Financial Institution: _________________________________________________________
Routing Number: ___________________________________________________________________
Account Number: ___________________________________________________________________

Check and complete one below:
☐ I authorize $ __________ to be charged to my card one time only.
☐ I authorize $ __________ to be charged monthly for as long as the equipment is on rent.
☐ I authorize $ __________ to be charged each month until my balance is paid in full.
☐ I authorize all charged if other than anniversary date ______________________________
Date credit card is to be charged if other than anniversary date ______________________________

Cardholder/Bank Account Owner Signature        Date

Information take by: ___________________________________           Branch: __________________
Post to invoice(s) (if known): _____________________________________________________
CONTACT INFORMATION

Thank you for choosing us for your home medical equipment and/or respiratory needs. If you need to reach us, our normal business hours are:

MONDAY-FRIDAY 8:30 AM TO 5:00 PM

FOR AFTER HOURS EMERGENCY CALLS (evenings, weekends, holidays), dial the phone number listed for the location nearest to your location. Our answering service will take your message or contact the Customer Service Representative or the Clinician as appropriate.

CORNERSTONE MEDICAL SERVICES
www.cornerstoneonecall.com

<table>
<thead>
<tr>
<th>Location</th>
<th>Phone</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Akron, OH</td>
<td>330-374-6802</td>
<td>330-615-3254</td>
</tr>
<tr>
<td>Barberton, OH</td>
<td>888-367-0202</td>
<td>513-554-0222</td>
</tr>
<tr>
<td>Cincinnati, OH</td>
<td>513-554-0222</td>
<td>888-574-0202</td>
</tr>
<tr>
<td>Cleveland, OH</td>
<td>440-244-9499</td>
<td>877-690-7302</td>
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<td>Columbus, OH</td>
<td>513-554-0222</td>
<td>330-297-2392</td>
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<tr>
<td>Ravenna, OH</td>
<td>888-574-0202</td>
<td>859-647-4276</td>
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LEGACY MEDICAL EQUIPMENT
www.legacymedical.net

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<tr>
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<tbody>
<tr>
<td>Troy, OH</td>
<td>937-335-9199</td>
<td>937-335-9199</td>
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<tr>
<td>Dayton, OH</td>
<td>937-298-9199</td>
<td>877-335-9199</td>
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MERCY HOME RESPIRATORY CARE AND MEDICAL SUPPLY
www.mercydm.com

<table>
<thead>
<tr>
<th>Location</th>
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<tbody>
<tr>
<td>Des Moines, IA</td>
<td>515-282-6902</td>
<td>515-282-6902</td>
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<tr>
<td>Clive, IA</td>
<td>800-642-4106</td>
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CENTRAL NEBRASKA HOME CARE
www.cnhconline.com

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<thead>
<tr>
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<th>Phone</th>
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</thead>
<tbody>
<tr>
<td>Kearney, NE</td>
<td>308-865-2711</td>
<td>308-865-2711</td>
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<tr>
<td>Grand Island, NE</td>
<td>308-384-9333</td>
<td>308-384-9333</td>
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</table>

ALEGENT CREIGHTON HEALTH AT HOME

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<tr>
<th>Location</th>
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<tbody>
<tr>
<td>Omaha, NE</td>
<td>402-898-8400</td>
<td>402-898-8400</td>
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<tr>
<td>Corning, IA</td>
<td>641-322-5453</td>
<td>641-322-5453</td>
</tr>
<tr>
<td>Shenandoah, IA</td>
<td>712-246-0067</td>
<td>712-246-0067</td>
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</table>

IMPORTANT! WHENEVER RENTING EQUIPMENT...

As noted under the Client/Patient Bill of Rights

PLEASE NOTIFY your local Branch

- should you require HOSPITALIZATION
- experience a CHANGE OF INSURANCE, and or
- go into a REHAB, or SKILLED facility
- CHANGE OF ADDRESS/PHONE #

This is a key importance to your continued quality of care. Thank you...

BILLING HOTLINE

If you have any billing questions, please call toll free 866-431-0202 for assistance. The Billing Center will be glad to help you Monday-Friday 8:30 am to 5:00 pm eastern standard time. Please have your account number available.