Active Medical LLC

120 Prosperous Pl Ste 103
Lexington, Ky 40515
859-421-1195

Patient Service Agreement

Patient Name:___________________________________ID_____________________________

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

Assignment of Benefits/Authorization for Payment: I hereby assign all benefits and payments to be made directly to Active Medical, LLC, for any home medical equipment, supplies and services furnished to me in conjunction with my home care. I authorize Active Medical, LLC, to seek such benefits and payments on my behalf. It is understood that, as a courtesy, Active Medical will bill Medicare/Medicaid or other federally funded sources and other payers and insurer(s) providing coverage, with a copy to Active Medical LLC. I understand that I am responsible for providing all necessary information and for making sure all certification and enrollment have been informed by Active Medical, LLC of the medical necessity for the services prescribed by my physician. I understand that in the event services are deem ed not reasonable and necessary, payment may be denied and that I will be fully responsible for payment.

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

Financial Responsibility: I understand and agree that I am responsible for the payment of any and all sums that may become due for the services provided. These sums include, but are not limited to, all deductibles, co-payments, out-of-pocket requirements, and non-covered services. If for any reason and to any extent, Active Medical, LLC does not receive payment from my payer source, I hereby agree to pay Active Medical, LLC for the balance in full, within 30 days of receipt of invoice. All charges not paid within 45 days of billing date shall be assessed late charges. I am liable for all charges, including collection costs and all attorneys cost. I am responsible for all charges regardless of my payer unless my agreement with my health plan holds me harmless.

______(Initials) I acknowledge that I have been advised of my financial obligations to Active Medical.

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

Patient Handouts: I acknowledge that I have received a copy of the Patient Handouts which contains Patient Rights and Responsibilities, Supplier Standards, Home Safety Information, HIPAA Privacy Standards, Emergency Planning, and Advance Directive Information. I acknowledge that I have received company marketing material and information on the company's scope of services. I acknowledge that the information in the Patient Handouts has been explained to me and that I understand the information. I understand my right to formulate and to issue Advance Directives to be followed should I become incapacitated. I will furnish Active Medical, LLC with a copy of such document.

Complaint Reporting: I acknowledge that I have been informed of the procedure to report a grievance should I become dissatisfied with any portion of my home care experience. I understand that I may lodge a complaint without concern for reprisal, discrimination, or unreasonable interruption of service. To place a grievance, please call 859-421-1195 and speak to customer services. If your complaint is not resolved to your satisfaction within 5 working days; you may initiate a formal grievance, in writing and forward it to the Governing Body. "The Compliance Team" @ thecomplianceteam.org. Or 215-654-9110. You can expect a written response within 14 working days of receipt.

You may also make inquiries or complaints about this by calling Medicare at 1-800-MEDICARE and/or the Kentucky Board of Pharmacy at https://pharmacy.ky.gov/Pages/Complaint-Process.aspx and/or the Kentucky Board of Durable Medical Equipment Supplies at 502-782-8816.

Patient:____Date:______________________

Witness:____Date:______________________