AKT MEDICAL, LLC.
15289 STONY CREEK WAY
NOBLESVILLE, INDIANA 46060

ELITE SEAT®

Patient Information and Equipment Agreement

IN ORDER TO PROCESS AN ELITE SEAT® FOR A PATIENT, PLEASE FOLLOW THE INSTRUCTIONS BELOW:

1. Complete the Prescription for Rehabilitation and Certification of Medical Necessity Form (Attached)
2. Complete the information below and obtain a patient signature in the Assignment of Benefit section
3. Include a photo copy of both sides of the patient's current insurance card.

Fax all information to: AKT Medical (317) 770-8360

AKT Medical will contact the patient's insurance company and determine the level of benefit that the patient is entitled. AKT Medical will notify the patient, the physical therapist (if involved) and the patient's physician and disclose the insurance company's decision in relation to the **ELITE SEAT®**. If the **ELITE SEAT®** is approved, AKT Medical will coordinate with the patient, the physician and/or physical therapy office to have the elite seat delivered.

Patient Information

Insured's Name ______________________ Home# ______________________ Cell #______________________

Work # ______________________Address ______________________

City______________________St. ______________ Zip ______________

Email ______________________Date of Birth ______________ Male ______ Female ______

Physician Information

Physician______________________

Address ______________________ City______________ St. ________ Zip ________

Telephone ______________________ Email ______________________

Physical Therapy Clinic ______________________ Physical Therapist ______________________

Address ______________________City______________ St. ________ Zip ______

Telephone ______________________ Email ______________________

Insurance Information

Insurance Company ______________________ Policy Group # ______________________

Policy Number ______________________ Patient ID ______________________

Claim # ______________ Telephone ______________ Date of Injury ______________

Case Manager Name ______________ Phone ______________ Email ______________

PLEASE INCLUDE A PHOTO COPY OF BOTH SIDES OF THE PATIENT'S CURRENT INSURANCE CARD

Assignment of Benefits

I authorize my physician to release to AKT Medical, and for AKT Medical to release to my insurer, any information needed to process a claim. I request that payment of authorized benefits be made on my behalf to AKT Medical. I authorize AKT Medical to submit a claim to any of the insurers as may be required. I understand that I am responsible for paying any amounts, including deductibles and co-payments that are not covered by my insurance prior to or upon receiving the unit. If I choose to take advantage of the "Pre-Payment Discount" option, I will not pay more than the agreed upon monthly discounted rate. AKT Medical will notify me of my covered benefit and its estimate of my obligation of an uncovered amount after contacting my insurance company. *I accept the terms of this agreement and have read the warranty and return information.*

Patients Signature ______________________ Date ______________

Patient Notice

As part of your treatment plan, your Health Care Provider has deemed it "medically necessary" for you to have the **ELITE SEAT®**. Based on your diagnosis and treatment protocol, the **ELITE SEAT®** may be rented. AKT Medical, LLC will bill your insurance carrier for the **ELITE SEAT®** you receive. Depending on your coverage, you may be responsible for some or all of the costs. The amount not covered by your insurance plan will be billed to you. Private pay options are always available.

MANUFACTURER'S WARRANTY: AKT MEDICAL *shall turn over, assign to, or pass through to the patient the manufacturer's warranty on the* **ELITE SEAT®**. Any defective or malfunctioning device will be replaced with a similar device. For questions relating to warranty information including but not limited to product performance, repair or replacement, please call (317) 770-8355 or e-mail claims@aktmedical.com. **Medicare beneficiaries receive *unconditional replacement or repair of defective products within a twelve month manufacturer warranty period, excluding normal wear and tear.***

PATIENT RIGHTS AND RESPONSIBILITIES:

Patient Rights:

1. The patient has the right to considerate and respectful service.
2. The patient has the right to obtain service without regard to race, creed, national origin, sex, age, disability, diagnosis or religious affiliation.
3. Subject to applicable law, the patient has the right to confidentiality of all information pertaining to his/her medical equipment service. Individuals or organizations not involved in the patient's care may not have access to the information without the patient's written consent.
4. The patient has the right to make informed decisions about his/her care.
5. The patient has the right to reasonable continuity of care and service.
6. The patient has the right to voice grievances without fear of termination of service or other reprisal in the service process.

Patient Responsibilities:

1. The patient should promptly notify the Home Medical Equipment Company of any equipment failure or damage.
2. The patient is responsible for any equipment that is lost or stolen while in their possession and should promptly notify Home Medical Equipment Company in such instances.
3. The patient should promptly notify the Home Medical Equipment Company of any changes to their address or telephone.
4. The patient should promptly notify the Home Medical Equipment Company of any changes concerning their physician.
5. The patient should notify the Home Medical Equipment Company of discontinuance of use.
6. Except where contrary to federal or state law, the patient is responsible for any equipment rental and sale charges which the patient's insurance company/companies does not pay.

HIPAA PRIVACY PRACTICE:

AKT Medical, LLC

PRIVACY NOTICE

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 Privacy Officer.

Each time you visit a physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, a plan for future care or treatment, and billing-related information. This notice applies to all of the records of your care generated by this practice.

Our Responsibilities

We are required by law to maintain the privacy of your health information and provide you a description of our privacy practices. We will abide by the terms of this notice.

Uses and Disclosures

<u>How we may use and disclose Medical Information about you.</u>

The following categories describe examples of the way we use and disclose medical information:

For Treatment: We may use medical information about you to provide treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you. For example, a doctor treating you for an infection may need to know if you have diabetes because diabetes may slow the healing process.

For Payment: We may use and disclose medical information about your treatment and services to bill and collect payment from you, your insurance company or a third party payer. For example, we may need to give your insurance company information about your surgery so they will pay us or reimburse you for the treatment.

For Health Care Operations: Members of the medical staff may use information in your health record to assess the care and outcomes in your case and others like it. The results will then be used to continually improve the quality of care for all patients we serve. For example, we may combine medical information about many patients to evaluate the need for new services or treatment. We may disclose information to doctors, nurses, and others for educational purposes.

We may also use and disclose protected health information:

- To remind you that you have an appointment for medical care, or to advise of test results;
- To assess your satisfaction with our services;
- To tell you about possible treatment alternatives;

- To tell you about health–related benefits or services; and
- For population based activities relating to improving health or reducing health care costs.

Business Associates: There are some services provided in our organization through contracts with business associates. When these services are contracted, we may disclose your health information to our business associate so that they can perform the service we require and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Research: If you are participating in a research project, we may disclose information to researchers when an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research.

Future Communications: We may communicate to you via newsletters, our website, mail outs or other means regarding treatment options, health related information, disease-management programs, wellness programs, or other community based initiatives or activities our practice is participating.

Affiliated Covered Entity: Protected health information will be made available to hospital personnel as necessary to carry out treatment, payment and health care operations. Caregivers at other facilities may have access to protected health information at their locations to assist in reviewing past treatment information as it may affect treatment at this time. Please contact the Privacy Officer for further information on the specific sites included in this affiliated covered entity.

As required by law, we may also use and disclose health information for the following types of entities, including but not limited to:

- Food and Drug Administration
- Public Health or Legal Authorities charged with preventing or controlling disease, injury or disability
- Correctional Institutions
- Workers Compensation Agents
- Organ and Tissue Donation Organizations
- Military Command Authorities
- Health Oversight Agencies
- Funeral Directors, Coroners and Medical Directors
- National Security and Intelligence Agencies
- Protective Services for the President and Others

Law Enforcement/Legal Proceedings: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of the healthcare practitioner or office that compiled it, you have the **Right to**:

- **Inspect and Copy**: You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.
- **Amend**: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the practice. We may deny your request for an amendment and if this occurs, you will be notified of the reason for the denial.
- **An Accounting of Disclosures**: You have the right to request an accounting of disclosures. This is a list of certain disclosures we make of your medical information for purposes other than treatment, payment or health care operations.
- **Request Restrictions:** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.
  We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.
- **Request Confidential Communications:** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you may ask that we contact you at work or by U.S. Mail. The practice will grant requests for confidential communications at alternative locations and/or via alternative means only if the request is submitted in writing and the written request includes a mailing address where the individual will receive bills for services rendered by the practice and related correspondence regarding payment for services. Please realize we reserve the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response. We will notify you in accordance with your original request prior to attempting to contact you by other means or at another location.
- **A Paper Copy of This Notice:** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To exercise any of your rights, please obtain the required forms from the Site Office Manager and submit your request in writing.

CHANGES TO THIS NOTICE

We reserve the right to change this notice and the revised or changed notice will be effective for information we already have about you as well as any information we receive in the future. The current notice will be posted in each office and include the effective date. In addition, each time you register for treatment, we will offer you a copy of the current notice in effect.

COMPLAINTS

If you wish to file a complaint, you may do so by contacting AKT Medical at (317) 770-8355 and asking for the Privacy/Compliance Officer. If you feel your complaint has not been properly addressed, contact the accrediting agency, The Compliance Team Inc., at (888) 291-3535 or the Secretary of the Department of Health and Human Services at (800) HHS-TIPS. **You will not be penalized for filing a complaint.**

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

30 MEDICARE SUPPLIER STANDARDS:

1. A supplier must be in compliance with all applicable Federal and State licensure and 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 Clearinghouse 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 to fill 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 rent or purchase inexp3ensive or routinely purchased durable medical equipment, and of the purchase option for capped rental equipment.
6. A supplier must notify beneficiaries of warranty coverage and honor all warranties under applicable State law, and repair or replace free of charge Medicare coverage items that are under warranty.
7. A supplier must maintain a physical facility on an appropriate site.
8. A supplier must permit HCFA, or its agents to conduct on-site inspections to ascertain the supplier's compliance with these standards. The supplier location must be accessible to beneficiaries during reasonable business hours, and must maintain a visible sign and posted hours of operation.
9. A supplier must maintain a primary business telephone listed under 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's place of business and all customers and employees of the supplier. If the supplier manufactures its own items, this insurance must also cover product liability and complete operations.
11. A supplier must agree not to initiate phone 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, and maintain proof of delivery.
13. A supplier must answer questions and respond to complaints of beneficiaries, and maintain documentation of such contacts.
14. A supplier must maintain and replace at no charge or repair directly, or thorough 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 to 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, i.e., the supplier may not sell 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. Complain records must include: the name, address, telephone number and health insurance claim number of the beneficiary, a summary of the complaint, and any actions taken to resolve it.
21. A supplier must agree to furnish HCFA any information required by the Medicare statute and implementing regulations.
22. A supplier of DMEPOS must be accredited by a CMS-approved accreditation organization in order to receive and retain a supplier billing number. This accreditation must indicate the specific products and services, for which the supplier is accredited in order for the supplier to receive payment for those specific products and services.
23. All DMEPOS suppliers must notify their accreditation organization when a new DMEPOS location is opened. The accreditation organization may accredit the new supplier location for three months after it is operational without requiring a new site visit.
24. All DMEPOS supplier locations must meet the DMEPOS quality standards and be separately accredited in order to bill Medicare. An accredited supplier may be denied enrollment or their enrollment may be revoked, if CMS determines that they are not in compliance with the DMEPOS quality standards.
25. All DMEPOS suppliers must disclose upon enrollment all products and services, including the addition of new product lines for which they are seeking accreditation. If a new product line is added after enrollment, the DMEPOS supplier will be responsible for notifying the accrediting body of the new products so that the DMEPOS supplier can be re-surveyed and accredited for these new products.
26. Must meet the surety bond requirements.
27. A supplier must obtain oxygen from a state-licensed oxygen supplier.
28. A supplier must maintain ordering and referring documentation consistent with provisions found in 42 C.F.R. 424.516(f).
29. DMEPOS suppliers are prohibited from sharing a practice location with certain other Medicare providers and suppliers.
30. DMEPOS suppliers must remain open to the public for a minimum of 30 hours per week with certain exceptions.

ELITE SEAT® RENTAL RETURN PROCESS INSTRUCTIONS

PLEASE KEEP THE ORIGINAL SHIPPING BOX AND PACKING MATERIALS FOR RETURN SHIPMENT

PLEASE KEEP THE UPS RETURN SHIPPING PAPERWORK FOR RETURN SHIPMENT

Once the rental term is completed, the return process is as follows:

1. Remove the UPS ground shipping return label from this envelope.

2. Fold unit, package with original packing materials and seal unit in box.

3. Adhere the pre-printed return shipping label over the previous shipping label on the box.

4. Drop off the unit at your nearest UPS drop off location. You may visit www.ups.com/dropoff to locate the drop off location nearest you. If there is not a drop off location convenient to your home you may call 1-888-889-4440 (WorldWide Express-UPS) to arrange a pick up at your residence.

The **ELITE SEAT**® is the responsibility and liability of the prescribed patient until the unit has been scanned by a UPS representative for return to AKT Medical.