LINCARE
A Linde company

Patient agreement and consent.

Account number: _____ Patient phone: _____

Patient name: _____ Email: _____

Address: _____ City/state/zip: _____

Equipment type: HME, DME and Supplies Effective date: _____

Request for products, equipment, supplies, services

The undersigned, being the above-named Patient ("Patient"), his/her guardian or representative payee, understands that by signing this **Patient Agreement and Consent,** the undersigned desires to rent or purchase, as or on behalf of Patient, certain medical equipment, products, supplies, prescription drugs, and/or associated services (collectively, to the extent applicable, the "Items") from Supplier and its affiliates.

Acknowledgment of medical responsibility and informed consent

The undersigned, as or on behalf of Patient, understands that (1) Patient is under the supervision and control of an attending physician; (2) Patient's physician has prescribed the Items noted as part of Patient's treatment; (3) Supplier's services do not include diagnostic, prescriptive, or other functions typically performed by physicians; and (4) Patient's physician is solely responsible for diagnosing and prescribing the Items or other therapies for Patient's condition and otherwise for controlling Patient's medical care. The undersigned, as or on behalf of Patient, has been informed by Patient's physician of the possible increased risks associated with in-home care, including possible delays in receiving treatment for life threatening conditions as a result of being outside the hospital setting. The undersigned, as or on behalf of Patient, has discussed his/her concerns with Patient's physician and has had all associated questions answered to his/her satisfaction.

Acknowledgments of receipt and agreement to contact

The undersigned, as or on behalf of Patient, acknowledges receipt of a copy of each of the following: (1) the **Medicare DMEPOS Supplier Statement**; (2) **Supplier's Notice of Privacy Practices;** (3) the **Patient's Bill of Rights;** and (4) the **Patient Responsibilities.** The undersigned, as or on behalf of Patient, agrees that Supplier and its affiliates may contact Patient at the phone numbers and/or email address specified hereon or as provided by the undersigned or Patient in the future.

Consent to release of health information for treatment, payment, and healthcare operations

The undersigned, as or on behalf of Patient, authorizes (1) Patient's insurer(s) and any other third party payor(s) which provide Patient with coverage to disclose to Supplier minimum necessary information to facilitate payment to Supplier for Items furnished Patient including but not limited to (A) payment made by such payor(s) to Patient, the undersigned or to any other person or entity for Items provided by Supplier to Patient; and (B) the scope and extent of Patient's coverage from time to time; (2) all medical personnel involved in Patient's treatment to disclose to Supplier any and all information concerning Patient's medical history and condition as it may relate to the Items or treatment provided to Patient by Supplier; and (3) any holder of medical information about Patient (including Supplier) to release to the Centers for Medicare and Medicaid Services (or any successor agency) and its agents, to any of Patient's third party payor(s) including, without limitation, Medicare, Medicaid, OCHAMPUS, Tricare or other public or private payors, and to Supplier, any information needed (subject to "minimum necessary" requirements, as applicable) (A) to determine applicable benefits and qualification for reimbursement of Items furnished by Supplier to Patient; (B) to process claims for Items provided by Supplier to Patient; and/or (C) to conduct healthcare compliance activities (including pre- and post-payment audits) and quality assurance and utilization reviews. The undersigned, as or on behalf of Patient, hereby authorizes his/her healthcare providers and payors to rely on this "Consent to Release of Health Information" without the need for a separate release authorization, to release the specified information for treatment, payment, and healthcare operations purposes as contemplated herein. This consent shall not be effective to permit disclosures of information in cases where a HIPAA-compliant release authorization is required by law, except that the undersigned authorizes the use or disclosure of health information to the extent communications made by Supplier are in exchange for financial remuneration from an affiliate whose product or service is being marketed.

Agreement to pay

The undersigned agrees to pay for all Items provided by Supplier to Patient. The monthly balance due will be that portion of Supplier's applicable charges not paid by insurance or any other payor, including coinsurance, co-payment and deductible amounts, as well as amounts due for non-covered Items provided to Patient by Supplier. The undersigned agrees to pay the balance due in full upon receipt of an invoice from Supplier. If prompt payment is not made, Supplier may pursue its standard collection policy or other applicable remedies at Supplier's sole discretion. If the undersigned fails to pay any amount due hereunder, he/she hereby grants Supplier a lien and security interest under the Uniform Commercial Code in any personal property of the Patient to secure payment. If payment is more than 90 days past due, Supplier may take all actions permitted by law to enforce the security interest and lien.

Patient agreement and consent. (continued)

Credit check authorization

The undersigned, as or on behalf of Patient, authorizes Supplier (1) to verify any financial or payment information disclosed by Patient or the undersigned and to perform a credit investigation for the purpose of extending credit for the purchase or rental of Items and (2) to answer any questions from other creditors about Patient's or the undersigned's credit and account experience with Supplier.

Assignment of benefits

The undersigned, as or on behalf of Patient, requests that payment of authorized benefits be made to Supplier, and authorizes Supplier to collect directly all public and private insurance coverage benefits due for any Items furnished to Patient by Supplier. In the event benefit payments due Supplier are paid directly to Patient or the undersigned, the payee shall immediately, and without request from Supplier, endorse and remit to Supplier all such benefit payment checks. On assigned Medicare claims, Supplier shall accept the applicable Medicare-allowable amount (including deductibles and co-payment) in full for covered Items.

Miscellaneous

The undersigned certifies that the information provided to Supplier by or on behalf of Patient under Medicare (Title XVIII of the Social Security Act) and/or any other public or private health insurance is correct. Patient, if physically and mentally competent, must sign this Patient Agreement and Consent on his/her own behalf. If Patient cannot sign for himself/herself, the source of the undersigned's authority to sign on behalf of Patient must be stated. This Patient Agreement and Consent is used in lieu of Patient's or his/her representative's signature on the "Request for Payment" HCFA-1500 and on other health insurance claim forms requiring signature and thus, is an extension of those forms. Any person who misrepresents or falsifies information in making a claim under Medicare or any other federal healthcare program may, upon conviction, be subjected to fines and imprisonment under federal law. Penalties may also result from falsification or misrepresentation of other health insurance claims.
A copy of this Patient Agreement and Consent may be used in place of the original.

The undersigned certifies that he/she (1) is the Patient, or is duly authorized to execute this Patient Agreement and Consent and accept its terms as or on behalf of Patient and (2) has read the foregoing and understands and agrees to the terms hereof as or on behalf of Patient.

Area manager	Telephone
Patient, guardian or authorized representative, authority to sign	Date
Witness	Date

Distribution of copies: Original – Lincare center, Yellow – reimbursement, Pink – patient

Patient's rights and responsibilities.

Patient's bill of rights

Supplier will function using the following guidelines while providing patient care. The patient/client has the right to:

1. Receive service without regard to race, creed, gender, age, handicap, sexual orientation, veteran status, or lifestyle.
2. Participate in decisions regarding his/her care.
3. Receive information in a manner in which he/she can understand and be able to give informed consent to the start of any procedure or treatment.
4. Be provided with information concerning those aspects of his/her condition related to the care provided by Supplier or other agencies contracted by Supplier.
5. Be informed of any responsibilities he/she may have in the care process.
6. Have care provided by qualified personnel who are knowledgeable to perform procedures at the level of care required.
7. Refuse treatment to the extent permitted by law and to be informed of the consequences of such action.
8. Be informed of the availability, upon request, of Supplier policies and procedures.
9. Be informed, at admission, of the organization's charges and policies concerning payment for services.
10. Discuss problems and suggest changes regarding the services or staff without fear of discrimination.
11. Privacy concerning his/her records.
12. Expect and receive care in a timely manner, appropriate to his/her needs.
13. Choose his/her home care provider.
14. Formulate advance medical directives, which are legal documents that allow him/her to give direction for his/her future medical care.
15. Be free from any mental or physical abuse, neglect, or exploitation of any kind by staff.
16. Have his/her property treated with respect.

Patient's responsibilities

As a home healthcare patient, you have the responsibility to:

1. Give accurate and complete health information concerning your past illnesses, hospitalization, medications, allergies, infections, diseases, and other pertinent Items.
2. Assist in developing and maintaining a safe environment.
3. Inform Supplier when you will not be able to keep a home care visit.
4. Participate in the development of and adherence to your home care plan of service/treatment.
5. Request further information concerning anything you do not understand.
6. Contact your physician whenever you notice any change in your condition.
7. Contact Supplier whenever you have an equipment problem or if you change physicians.
8. Contact Supplier whenever you have received a change in your home care prescription.
9. Contact Supplier whenever you are to be hospitalized or receive services from a home health agency pursuant to a Medicare plan of care.
10. Give information regarding concerns and problems you have to Supplier.
11. Ensure that the financial obligation for your equipment is fulfilled promptly.
12. Maintain and repair purchased equipment when equipment is no longer under warranty.
13. Follow equipment care procedures as outlined on Equipment Orientation Form.

Supplier is a direct or indirect subsidiary of Lincare Holdings, Inc. Lincare Holdings, Inc. is owned by Linde North America Holdings Limited, a privately held company. If you feel that Supplier has not respected your rights, we would ask that you please contact our area manager (shown on reverse side). It is the area manager's responsibility to review all formal complaints, and you will be entitled to a written response to your formal complaint. If feel you have not received satisfactory resolution, you may contact CHAP at 800.656.9656. I have reviewed and understand the Patient's Bill of Rights and my Patient/Client Responsibilities.

Patient bill of rights.

WAC 246-335-535 A home health agency at the time of admission must provide each patient, designated family member, or legal representative with a written bill of rights affirming each patient's right to:

1. Receive effective treatment and quality services from the home health agency for services identified in the plan of care;
2. Be cared for by appropriately trained or credentialed personnel, contractors and volunteers with coordination of services;
3. A statement advising of the right to ongoing participation in the development of the plan of care;
4. A statement advising of the right to have access to the department's listing of licensed home health agencies and to select any licensee to provide care, subject to the individual's reimbursement mechanism or other relevant contractual obligations;
5. A listing of the total services offered by the home health agency and those being provided to the patient;
6. Refuse specific treatments or services;
7. The name of the individual within the home health agency responsible for supervising the patient's care and the manner in which that individual may be contacted;
8. Be treated with courtesy, respect, and privacy;
9. Be free from verbal, mental, sexual, and physical abuse, neglect, exploitation, and discrimination;
10. Have property treated with respect;
11. Privacy and confidentiality of personal information and health care related records;
12. Be informed of what the home health agency charges for services, to what extent payment may be expected from health insurance, public programs, or other sources, and what charges the patient may be responsible for paying;
13. A fully itemized billing statement upon request, including the date of each service and the charge. Agencies providing services through a managed care plan are not required to provide itemized billing statements;
14. Be informed about advanced directives and POLST and the agency's scope of responsibility;
15. Be informed of the agency's policies and procedures regarding the circumstances that may cause the agency to discharge a patient;
16. Be informed of the agency's policies and procedures for providing back-up care when services cannot be provided as scheduled;
17. A description of the agency's process for patients and family to submit complaints to the home health agency about the services and care they are receiving and to have those complaints addressed without retaliation;
18. Be informed of the department's complaint hotline number to report complaints about the licensed agency or credentialed health care professionals; and
19. Be informed of the DSHS end harm hotline number to report suspected abuse of children or vulnerable adults.
20. The home health agency must ensure that the patient rights under this section are implemented and updated as appropriate.

[Statutory Authority: RCW 70.127.120 and 43.70.250. WSR 18-06-093, § 246-335-535, filed 3/6/18, effective 4/6/18.]

Health facilities survey section hotline
If you have a complaint with Home Health, call the HFSS hotline 1.800.633.6828.
We'll have someone contact you to discuss the problem and help resolve it.
Calls are received from 8am to 5pm, Monday through Friday.

Washington State
Department of Health
DOH-PUB-550-001

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