Hillrom™

Advanced Respiratory, Inc.,
A Hill-Rom Company

1020 West County Road F
St. Paul, Minnesota 55126
P: 800-426-4224 or 651-490-1468
F: 866-643-5787
respiratorycare.hill-rom.com

TERMS, CONDITIONS AND RESPONSIBILITY

Mechanical Insufflation-Exsufflation (MIE) Device, Supplies and Accessories

Advanced Respiratory, Inc. ("ARI"), a Hill-Rom company, is being asked to supply Mechanical Insufflation-Exsufflation Device, Supplies and Accessories. If you have questions about this form, please contact ARI's Customer Service team at **1-800-426-4224** before signing.

PATIENT/CUSTOMER NAME: _____ **PATIENT ACCOUNT NUMBER:** _____

1. HEALTH INFORMATION PRIVACY

I understand that data relating to my usage of the MIE device may be accessed, used or disclosed to ARI and my healthcare provider(s) in order to coordinate my care and treatment. De-identified data regarding device usage may be aggregated and reviewed in order to provide treatment benchmarking information to ARI and my healthcare team. I acknowledge that I received ARI's Notice of Privacy Practices, which further describes how ARI may use and disclose my health information, as well as my rights under certain privacy laws.

2. FINANCIAL RESPONSIBILITY

I understand that ARI will work with me to obtain reimbursement from my insurance carrier(s) and has programs to support patients through the reimbursement process, including providing appeal assistance. I further understand that ARI has interest-free payment plans and patient financial assistance for those patients who qualify financially and have an established need to receive medically necessary medical services. I acknowledge that I am able to and will promptly return my device, at no cost, if ARI is unable to obtain reimbursement from my insurance carrier(s) and I do not make other financial arrangements to pay ARI for the equipment.
I am responsible for any amounts not covered by my insurance carrier(s), including any applicable co-payments and deductibles. I also agree to cooperate with the reimbursement process and assist in any appeal.
It is my responsibility to return all rental equipment to ARI if: 1) I stop using the equipment; 2) the medical order for the equipment ends or is discontinued; 3) I fail to make acceptable financial arrangements for any amounts not covered by my insurance carrier(s); or 4) ARI reasonably requests that I return the equipment.

3. **ASSIGNMENT OF BENEFITS AND AUTHORIZATION OF THIRD-PARTY PAYMENT**

I authorize ARI to submit insurance carrier claims on my behalf for the products and services provided by ARI. I authorize payment of medical benefits be made directly to ARI for Mechanical Insufflation-Exsufflation Device, Supplies and Accessories provided to me by ARI.
ARI accepts assignment unless ARI enters into a separate written and signed agreement with me that specifically states that ARI is not accepting assignment.

Signature of Patient or Patient's Authorized Representative:

_____ Date: _____
Signature (MM/DD/YYYY)

Authorized Representative's Relationship to Patient and Address (Required when Authorized Representative is signing):

_____ _____
Printed Name Relationship

_____
Address

Check reason patient unable to sign:

☐ Patient/customer is under 18.

☐ Patient/customer is physically or cognitively unable to sign on their own behalf.

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TERMS, CONDITIONS AND RESPONSIBILITY FORM

By accepting this product and any replacement products, you (patient/caregiver/legal guardian) represent that you understand and acknowledge that ARI retains ownership of the equipment until the equipment is paid in full. Some insurance carrier(s), including certain government programs may require ownership of the equipment be transferred to the insurance provider. In these and other instances where you do not own the equipment, ARI may need to (re)enter the home to perform certain tasks related to title transfer activities. By accepting the product, you agree to comply with all such requirements and to grant access to the home, as needed. Please contact your insurance carrier(s) if you have questions regarding transfer of equipment ownership.

The method of payment your insurance company will make is dependent on the respiratory device you are receiving. Medicare beneficiaries receiving a product Medicare deems a capped rental, 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.

If you are receiving a product that is not deemed a Medicare capped rental, your insurance may pay for the device on continuous or capped monthly rental, or a one-time purchase payment. In some of these payment scenarios and until the equipment is paid in full, ownership of the equipment may transfer to the beneficiary.

In instances where ownership of the equipment is transferred to the beneficiary, and the warranty period has expired, it is the beneficiary's responsibility to arrange for any required equipment service or repair.

ADDITIONAL NOTIFICATIONS FOR RESIDENTS OF MAINE

The person signing this authorization may receive a copy of this authorization.
A patient may refuse authorization to disclose some or all health care information, but that refusal may result in improper diagnosis or treatment, or denial of coverage of a claim for health benefits or other insurance. This authorization may be revoked at any time, subject to the right of the person acting in reliance on the authorization to use such revocation as the basis for denial of coverage.

ADDITONAL NOTIFICATIONS FOR RESIDENTS OF RHODE ISLAND

The person signing this authorization may receive a copy of this authorization.
Consent may be withdrawn at any time except where an authorization is executed in connection with a claim for benefits, and if so, the authorization is valid for the duration of the claim.

Visit www.hillrom.com to access the Notice of Privacy Practices and product information.

Please fax the front of this form to 1-866-643-5787
or email mhrcaritrainingcoord@hill-rom.com

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Employees and Contract Trainers
Signature Requirements for Advanced Respiratory. Inc.

1) Advanced Respiratory, Inc., employees/Contracted Trainers may NOT sign someone else's name - even with permission. This includes "stamping" a patient's signature with a signature stamp.

2) Advanced Respiratory, Inc., employees/Contracted Trainers may NOT date another person's signature - even with permission.

3) **Signature stamps & "Mark" (X)**

Advanced Respiratory Employee/Contract Trainer may NOT stamp the signature or "Mark" (X) for the patient.

If signature stamp is used:
Employee/Trainer writes a note: "patient stamped own signature on _____ (fill in date), then sign and date.
Insured OR Authorized Agent stamps patient's signature.
Person stamps patient's signature, AND Person stamping patient's signature writes out the following information: their name, relationship to the patient, address, and reason the patient can't sign.

If signing with a "Mark" (X):
A patient may sign with an "X" if he/she is unable to write his/her name. Two witnesses must certify use of the "Mark" by their signature and date.
One of these witnesses may be an Advanced Respiratory, Inc., employee/contracted trainer.
The second witness (non-ARI employee/Trainer) must sign his/her name, write his/her address and date.

Correction Procedures
One line through the error, correct, initial and date.

Example:
Account Code: 1039282 1029282 DH 12/16/04

Patient Name: Sally Reed Reid DH 12/16/04
No white-out, blacking out, scribbling, cutting and pasting, etc.

Need to be able to read what the error was prior to it being corrected.
Corrections or changes made after the patient or responsible party signs the TCR and/or ABN, must be initialed and dated by the person signing the document – acknowledging that the addition/change was made. However, you can only correct.

