BENEFICIARY CHECKLIST

Patient Name SANJAY Singhania

Medicare Number: _____

STAFF PLEASE INITIAL ALL BELOW AND HAVE PATIENT SIGN AT THE BOTTOM:

Called Medicare to verify eligibility

HIPAA privacy policy

Equipment warranty policy

Protocol for resolving complaints

Supplier standards

Assignment of benefits

Delivery ticket

Instructed on use

I have received and understand the above information.

11/02/2017 10:41 AM

Patient's Signature

Date

Assignment of Benefits, Release of Information Authorization
and Insurance Coverage Disclosure

Patient/Customer Name SANJAY Singhania
Street Address ADDRESS 1
City CITY 4 State Arizona Zip Code 787878
Social Security Number dgf
Home Telephone Number
Other Telephone Number

By signing and dating this form, I hereby grant authorization for the following to ADVANCED PHYSICAL THERAPY OF CENTRAL FLORIDA, INC., a medical service, equipment and supply provider and their agents assigns:

a. To be granted and accept assignment of payments for Medicare, Medicaid, Medicare Supplemental or other medical insurance benefits for services, equipment and/or supplies furnished to me.

b. To submit claims or invoices to Medicare, Medicaid, or my other medical insurer(s), directly on my behalf, for services, equipment and/or supplies furnished to me.

c. To release my medical information or other pertinent information to Medicare, Medicaid, Medicare Supplemental, or other insurer or their agent or assigns.

d. To request, receive, and maintain in their files, medical or other information necessary to process my orders, submit claims, receive payment and comply with applicable rules, guidelines, regulations, and laws governing the services, equipment and/or supplies furnished to me.

e. To contact me by telephone or mail regarding services, equipment and/or suppliers.

f. To bill me directly for approved amounts not covered by Medicare, Medicaid, Medicare Supplemental or other medical insurance benefits.

This authorization/release form covers all services and supplies provided to me by ADVANCED PHYSICAL THERAPY OF CENTRAL FLORIDA, INC. including the following equipment:

Fusion OA Knee Brace

I have read, understand, and agree with the information on this authorization/release form.

Patient/Customer Signature — 11/2/2017 10:41:53 AM Date Signed

If other than Patient/ Customer * — Date Signed

SANJAY Singhania
Print Name — Telephone Number

ADDRESS 1 — CITY 4 ,Arizona ,787878
Street Address — City, State, Zip Code

* Relationship to Patient/Customer:

_____ Authorized Caregiver

_____ Authorized Family Member

_____ Other, please describe: _____

Advanced Physical Therapy of Central Florida, Inc.
5036 SE 110th Street
Belleview, FL 34420
Phone:352-693-3378 Fax:888-758-9645

First Name: SANJAY Middle: Last: Singhania

Address: ADDRESS 1

City: CITY 4 State: Arizona Zip Code: 787878

Phone #: Alt. Ph#:

Sex: Male Height: Weight lbs.

Date of Birth: 04/06/2001 Social Security #: dgf

Medicare #: Medicaid #:

Commercial / Supp. Insurance:

Policy #: Group #:

Address:

City: State: Zip:

Phone #:

Diagnosis	ICD-10 Code
Staphylococcal arthritis, left knee	A20.7

M.D. Phone:

Address:

City: State: Zip:

UPIN: NPI:

Equipment Delivered (including Description)

HCPCS Code + Modifier
L1847 Null

Qty.	Manuf.	Model	Serial#	Size
1	Medi USA	Fusion OA Knee Brace	N/A	

Received By: Date: 11/2/2017 10:41:53 AM

Advanced Physical Therapy of Central Florida, Inc.

Statement of Privacy Notice

Effective June 1, 2003

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.

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

We may disclose your health information in the course of any administrative or judicial proceeding.

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

We may disclose your health information to coroners or medical examiners.

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

We may disclose your health information for military, national security, prisoner and government benefits purposes.

We may leave a message on an automated answering device or person answering the phone for the purposes of scheduling appointments. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."

We may contact you by phone, mail, or email. "It is our practice to participate in charitable and marketing events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity.

In the event that we are sold or merged with another organization, your health information/record will become the property of the new owner.

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that we are not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that we amend your protected health information. Please be advised, however, that we are not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by us.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

We reserve the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, we are required by law to comply with this Notice.

We are required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact us by calling this office at (352) 693-3378, EXT 5. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints about your Privacy rights, or how we have handled your health information should be directed to our Privacy Officer by calling this office at (352) 693-3378, EXT 5. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

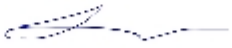
DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Advanced Physical Therapy of Central Florida, Inc. with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

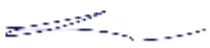
SANJAY Singhania

Patient's Name (print)



11/2/2017 10:41:53 AM

Patient's Signature Date



11/2/2017 10:41:53 AM

Authorized Facility Signature Date

Advanced Physical Therapy of Central Florida, Inc.
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Effective June 1, 2003

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We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

We may disclose your health information in the course of any administrative or judicial proceeding.

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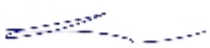
SANJAY Singhania

Patient's Name (print)

11/2/2017 10:41:53 AM

Patient's Signature Date



11/2/2017 10:41:53 AM

Authorized Facility Signature Date

PROTOCOL FOR RESOLVING COMPLAINTS FROM MEDICARE BENEFICIARIES

The patient has the right to freely voice grievances and recommend changes in care or service without fear of reprisal or unreasonable interruption 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 the patient's 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 a summary of the 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.

The patient will be informed of this complaint resolution protocol at the time of setup of service.

EQUIPMENT WARRANTY INFORMATION FORM

Every product sold or rented by our company carries a 1-year manufacturer's warranty. ADVANCED PHYSICAL THERAPY OF CENTRAL FLORIDA, INC. will notify all Medicare beneficiaries of the warranty coverage, and will honor all warranties under applicable law.

ADVANCED PHYSICAL THERAPY OF CENTRAL FLORIDA, INC. 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 medical equipment where this manual is available.

MEDICARE DMEPOS SUPPLIER STANDARDS

Note: This is an abbreviated version of the supplier standards every Medicare DMEPOS supplier must meet in order to obtain and retain their billing privileges. These standards, in their entirety, are listed in 42 C.F.R. 424.57(c).

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 hs 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 inexpensive 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 covered items that are under warranty.

7. A supplier must maintain a physical facility on an appropriate site.

8. A supplier must permit CMS, 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 fisted 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 completed operations.

11. A supplier must agree not to initiate telephone 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 ntaintain and replace at no charge or repair directly, or through 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 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. Complaint 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. All supplier must agree to furnish CMS any information required by the Medicare statute and implementing regulations.

22. All suppliers must be accredited by a CMS-approved accreditation organization in order to receive and retain a supplier billing number. The accreditation must indicate the specific products and services, for which the supplier is accredited in order for the supplier to receive payment of those specific products and services (except for certain exempt pharmaceuticals).

23. All suppliers must notify their accreditation organization when a new DMEPOS location is opened.

24. All supplier locations, whether owned or subcontracted, must meet the DMEPOS quality standards and be separately accredited in order to bill Medicare.

25. All suppliers must disclose upon enrollment all products and services, including the addition of new product lines for which they are seeking accreditation.

Palmetto GBA
National Supplier Clearinghouse
P.O. Box 500142 • Columbia, South Carolina • 29202-3142 • (866) 2384652

A CMS Contracted Intermediary and Carrier