AdaptHealth LLC
Payment Financial Policy

Prior to receiving products, AdaptHealth requires a form of payment on file to satisfy any balances that are not paid by your insurance. This will include the patient portion of charges incurred in future months.

To satisfy this requirement, we must have a form of payment in our billing system. We accept Visa, MasterCard, Discover, American Express and electronic debit from a bank account. All payment account information will remain confidential and securely stored by our PCI compliant merchant processor.

We have your insurance and require a form of payment to be secured for all patient balances including recurring rental and purchase costs. A statement will be sent to you outlining the amount you owe prior to the amount being charged to your credit card or drafted from your bank account. This will occur monthly if you are being set up with equipment that your insurance chooses to rent. Medicaid beneficiaries are exempt from this policy and do not require a payment method to be on file for services.

Patients being discharged from the hospital often do not have credit cards with them. In order to provide you with AdaptHealth equipment today, you must agree to provide a credit card or bank information to us within 5 working days.

eDelivery is an electronic invoicing process. With eDelivery, AdaptHealth will email your billing information to you instead of a mailed paper invoice, including your AutoPay Balance Due Notice. Upon set up you will receive a welcome email. Each invoice email you receive will contain a link to make a one time payment or register for the patient portal. Going forward all billing information will be emailed from "noreply@adapthealth.com".

Payment Authorization for Automatic Payment

I, **Lanh Nguyen**, ☐ AUTHORIZE ☑ DO NOT AUTHORIZE

AdaptHealth and its subsidiaries to initiate a recurring electronic debit/credit and or payment to my account from the financial institution that I provided for my medical equipment/supplies for the duration of the equipment rental and/or to satisfy all balances due for equipment/supplies received. I agree that credit and ACH transactions that I authorize comply with all applicable laws and that I am a signer on the account given to be debited/charged. I understand that this authorization will be effective on the date of my signature and will remain in full force and effective until I notify AdaptHealth in writing or by phone (855-389-4043) that I wish to revoke this authorization. I understand that AdaptHealth requires at least 30 days prior notice to cancel this authorization.

Reason for not authorizing: Medicare Straight w/Sec or Medicaid

Electronic Invoicing Authorization

☐ AUTHORIZE ☑ DO NOT AUTHORIZE

AdaptHealth and its subsidiaries to send my billing information electronically through the email address I have provided.

Signature	Relationship To Patient	Reason Beneficiary Could Not Sign
Michael Jones	Other: son in law	Not home
		Date Signed: 05/31/2024
AdaptHealth Representative	Uhlrig, Gregg	Date Signed: 05/31/2024

Date of Discharge

Patient Name: Lanh Nguyen
Responsible Party Email Address:
Phone Number: (415) 419-1219

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DELIVERY TICKET

myAPP
adapthealth
Sign up for myAPP today

Sales Order: 25394575
Customer ID: 5344240

AeroCare Home Medical Equipment 7076
Universal Ave
Kansas City, Missouri 64120-1370
Phone: 816-832-4299

Customer: Lanh Nguyen **DOB:** 01/01/1941 **Height:** 0.0 **Weight:** 0.0 **Sex:** Female

Bill to: 8807 NE 89TH ST
KANSAS CITY, Missouri 64157-8578
(415) 419-1219

Deliver to: 8807 NE 89TH ST
KANSAS CITY, Missouri 64157-8578
(415) 419-1219

Insurance Aetna - Natl - _ - _ - All Branches Medicaid - MO - _ - _ - Over 21 **HIPAA Signature on file** ☑

Any patient financial responsibility quoted is only an estimate and is subject to individual plans, supplemental insurance, pricing changes and your deductible or copay amounts.

Comments or Special Instructions

FRIDAY DELIVERY O2@4LPM-CONTINUOUS PT IS HOME - PLS CALL WHEN ON WAY

Delivery Date		Time	CSR	Branch			
05/31/2024		04:21 PM	Hostin, Alana	MO Kansas City - 57007			
Qty	**P/U**	**Type**	**Item**	**Ext. Allow**	**Ext. Charge**	**Tax**	**Co-Pay**
Warehouse			WAREHOUSE				
1		Rental	Oxygen Concentrator Manufacturer: Hours: Pressure: Purity: SN: Serial: 308051002243281945 Item Id: E1390 Make: 3B Medical Model: Stratus 5	$92.37	$143.49	$0.00	$0.00
1		Rental	Oxygen Portable Gas System Rental Manufacturer: Medical Oxygen USP Compressed Item Id: E0431	$14.74	$22.90	$0.00	$0.00
3		Purchase	Oxygen Contents Gas Port Lot: 051724 2314 Size: E Item Id: CONTENT DELIVERY	$35.90	$46.66	$0.00	$0.00
1		Purchase	E Tank Contents Only Manufacturer: Medical Oxygen USP Compressed Lot: 052424 2415 Size: E Item Id: OX-E	$0.00	$0.00	$0.00	$0.00
			TOTAL	$143.01	$213.05	$0.00	$0.00

Equipment Receipt, Setup and Safety – Instruction with Customer Demonstration of Understanding.

+ I acknowledge receipt of the above items/services and agree they are clean and in good working order. I understand the item(s) have been checked, tested and counted. Discrepancies must be reported within five (5) days of receipt. I have participated in the home assessment and equipment education process.

+ I have read the information provided to me and understand the physician's intended use of the prescribed equipment.

+ I have been informed of the safety considerations for the equipment. I understand my responsibility for conducting routine maintenance and keeping the equipment clean.

+ I have had an opportunity to demonstrate the use of the equipment to The Company representative. My questions have been answered.

+ I understand that I may contact The Company any time, if I have questions regarding the proper and safe use of the equipment or to make notice the equipment is not functioning properly.

+ I acknowledge that I have received the warranty information (if applicable) for the product(s) dispensed to me.

+ I have been instructed howto contact The Company. I have been informed of the company's on-call policy.

+ I understand bathroom equipment and items worn next to the skin are non-refundable.

+ I knowingly and voluntarily release The Company from any and all claims and/or liabilities for injuries to my person or property that arise from improper use of this equipment.

Notices
I acknowledge receipt of The Company's Welcome Guide, which includes but is not limited the following notices:

+ I have received the Notice of Privacy Practices and understand the types of uses and disclosures of my protected health information (PHI) that might occur in my treatment, payment of my invoices, or in the performance or our company's health care operations. The Notice of Privacy Practices also describes my rights & The Company's duties with respect to my PHI.

+ I have received the Patient's Rights and Responsibilities

+ I have received the Medicare Supplier Standards Statement

+ I have received the Complaint Reporting Procedure

+ I have received the branch location contact information and hours of operation

+ I have received Emergency Preparedness Procedures

+ I have received information related to my financial responsibilities

+ I have received information related to subcontractor relationships, if applicable

+ I understand if the equipment received is in the Medicare category of inexpensive or routinely purchased items, it can either be rented up to the allowable purchase price, at which time the title will transfer to the beneficiary or be purchased within the first month. I choose to purchase the equipment categorized as inexpensive or routinely purchased.

+ I understand merchandise may be accepted for exchange or refund within 30 days of purchase when accompanied by a sales receipt. To receive a refund the item must be new and in the original packaging. Undergarments, stockings, items worn next to the skin, oxygen, disposable supplies, diagnostic instruments or any opened sterile or packaged goods will not be accepted for return, refund or credit, unless the item is substandard or otherwise defective. Custom manufactured equipment, braces, or supplies will not be accepted for return. Refunds are subject to the discretion of AdaptHealth management.

CONSENT FOR TREATMENT: The Items/Services to be provided to me by The Company have been explained to me. I certify that I am a patient/customer The Company and I hereby authorize any employee or agent of The Company to treat and/or care for me. I further authorize and direct employees and agents of The Company to enter my property or property in my control for the purpose of delivering/pickup of Items or for administering agreed-upon services as ordered by my attending physician.

INSURANCE BENEFITS: I certify that I have provided The Company with all information related to insurances for which I am eligible, if any, and that they have been reviewed with me. I will notify The Company if my insurance changes.

RELEASE AND USE OF INFORMATION:
I hereby consent and state my preference to have the Company communicate with me by email or SMS messaging ***to the email address and numbers listed below*** *regarding various aspects of my medical care, which may include, but shall not be limited to, test results, needed documentation, required appointments, equipment performance, available replacement products & billing. I understand that email and SMS messaging are not confidential methods of communication and may be insecure. I further understand that, because of this, there is a risk that email and SMS messaging regarding my medical care might be intercepted and read by a third party.*

Phone Number(s): (415) 419-1219 ***Email Address(es): mylaiviet@gmail.com***

I hereby authorize AdaptHealth LLC and its affiliates to deliver or cause to be delivered to me a telephonic sales call ***to the phone number(s) below*** *using an automated system for the selection or dialing of telephone numbers, the playing of a recorded message when a connection is completed to a number called, or the transmission of a prerecorded voicemail. I am not required to authorize such calls, messages, or voicemails as a condition of entering into any agreement with AdaptHealth LLC or purchasing any products or services from AdaptHealth LLC.*

Phone Number(s): (415) 419-1219

I further understand that in the course of providing services to me, the Company and its employees and agents will receive (either from me or from others such as physicians) personal information and knowledge about my health, physical condition, treatment and care that I require, including knowledge about my living conditions and my relationship family and others (hereinafter referred to as Personal Health Information (PHI)). In that regard, I also authorize the Company to release my PHI (A) to my insurers and any agencies, institutions or individuals (including my physicians) who provide me with heath or social services, (B) to the Company's peer review organizations and licensing and accrediting organizations for the purpose of evaluating the Company's provision of services, (C) in connection with any audit or similar review (whether internal or conducted by a third party organization), or (D) to CMS or a commercial payer as may be required for continued certification of the Company.

ASSIGNMENT OF BENEFITS:

+ I hereby request that payment of authorized carrier benefits be made on my behalf to The Company for authorized products and services that have been provided to me. It is my intent to assign The Company all benefits for services provided to me by AdaptHealth LLC and its Affiliates beginning with the above date.

+ I authorize a copy of this agreement to be used in place of the original and authorize any holder of my medical information to release to Centers for Medicare & Medicaid Services, any other insurer, and/or their agents any information needed to determine my insurance benefits. + I agree to be fully responsible for all charges not covered by my insurance.

FINANCIAL RESPONSIBILITY:

+ I understand that by signing below I will be financially responsible for the above equipment and patient balances resulting from the use of the above equipment.

+ I give The Company the right to appeal denied claims on my behalf. Patient balances include, but are not limited to, patient co- insurance and deductible responsibilities, claims denied by my insurance carrier (s) and non-covered services.

+ I understand equipment classified as rental equipment is the property of The Company and will be returned to the company when the need has ended, otherwise a patient balance for the retail cost of the equipment will be applied to the account.

+ The credit card on file that I have provided verbal authorization to use will be charged for all one-time and recurring patient balances.

+ I understand if I fail to pay amounts due to The Company, The Company has the right to secure return of any items I have obtained from The Company with 10 days prior notice.

+ I understand that if the device or equipment is lost, stolen or damaged while in my possession, I am responsible to pay The Company for the replacement of the equipment or supplies if not covered under insurance of any kind.

BY SIGNING BELOW, I agree that (a) I am or am authorized to sign on behalf of the Customer/Beneficiary; (b) a copy of the above terms and conditions will be retained by The Company and The Company can use a copy of this document in lieu of the original; and (c) my signature as the party taking delivery of items on behalf of the Customer/Beneficiary indicates full understanding, compliance, responsibility and agreement with the above terms without exception.

Next Doctor's Visit Scheduled	Payment Type / Amount to be Collected None / $0.00

Setup Method: None

Signature	**Relationship To Patient**	**Reason Beneficiary Could Not Sign**
Michael Jones	Other: son in law	Not home
		Date Signed: 05/31/2024
AdaptHealth Representative	Uhlrig, Gregg	Date Signed: 05/31/2024

Home Assessment & Plan of Care

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Acknowledgment of Receipt of Patient Booklet

I, the undersigned, hereby acknowledge that I have received the AdaptHealth Welcome Guide. I am either the patient or a representative signing on behalf of the patient. The AdaptHealth Representative has explained the Welcome Guide, and I have had the opportunity to ask questions, and have my questions answered. I am aware that, should I have any questions or problems with my equipment or supplies, I can call AdaptHealth at the telephone number provided to me.

The AdaptHealth Representative has done an assessment of my home, verbally or in person, and has identified items or areas that need to be changed to improve the safety of my environment. I have made note of these items or areas, and assume responsibility for making the suggested changes, or the responsibility for not making the changes.

Education Objectives

- Understands and can verbalize the prescription written by the physician
- Understands, can verbalize and demonstrate the function and purpose of the equipment
- Understands and can demonstrate safe operation and preventative maintenance of the equipment
- Understands and can verbalize how and when to order supplies, call for repairs and emergency procedures
- I have been advised of certain equipment warranty and rent/purchase options available to me

Safety Objectives:

- Fire Extinguisher is present/recommended
- Smoke Alarms are present/recommended and functional
- Fire Escape plan has been developed
- Electrical outlets, grounding is recommended
- Electrical appliances are kept away from water
- Extension cords are out of pathways
- Circuits are not overloaded
- Frayed cords are disposed of
- Equipment and supplies are properly placed or stored
- Smoking is prohibited in bed, around open flames, and/or around oxygen

Home Evaluation:

☑ Home is suitable for the safe use of the ordered equipment

Patient Residence:

❑ Apartment	❑ Single Story	☑ Multi Level	❑ Grass
☑ Paved Driveway	❑ Gravel	❑ Dirt	❑ Tile
☑ Carpet	❑ Vinyl	☑ Hardwood	❑ W/C ramp inside or out
❑ Throw rugs	❑ Loose uneven floors	❑ Stairs	

Functional Limitations:

❑ Vision Impaired	❑ Ambulatory impaired	❑ Hearing Impaired	❑ Speech Impaired
❑ Paralysis	❑ Dyspnea	❑ Other	☑ None

Activities:

☑ No Restrictions ❑ Up as Tolerated ❑ Transfers to Bed ❑ Requires Assistance

Patient Status:

❑ Lives Alone ❑ Spouse ❑ Home Health ❑ Caregiver

☑ Able and Willing Caregiver

Fall Risk:

❑ High ☑ Medium ❑ Low ❑ Education Provided?

Environmental Safety:

❑ No Heat ❑ No Water ❑ Cluttered ❑ Pets

❑ Generator ☑ None

Signature	**Relationship To Patient**	**Reason Beneficiary Could Not Sign**
Michael Jones	Other: son in law	Not home
		Date Signed: 05/31/2024
Adapt Health Representative	Uhlrig, Gregg	Date Signed: 05/31/2024

Patient Authorization to Release Protected Health Information

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I understand that it is the policy of Adapthealth and its affiliates (collectively Adapthealth) to keep all patient records and patient information confidential. In addition, I understand that by completing this request I am authorizing the person/persons listed below to receive information regarding my protected health information including but not limited to: providing payment or insurance information, discussing information regarding my care, and ordering supplies, medications, or equipment on my behalf.

I understand this authorization will remain in place until I have submitted to Adapthealth a written request that the authorization be modified or revoked entirely.

Authorized Person to Receive PHI:

Name: Relationship to Patient:

Release Method: ❑ Verbal ❑ Written ❑ Electronic

Name: Relationship to Patient:

Release Method: ❑ Verbal ❑ Written ❑ Electronic

Name: Relationship to Patient:

Release Method: ❑ Verbal ❑ Written ❑ Electronic

Signature	Relationship To Patient	Reason Beneficiary Could Not Sign
Michael Jones	Other: son in law	Not home
		Date Signed: 05/31/2024
Adapt Health Representative	Uhlrig, Gregg	Date Signed: 05/31/2024

Respiratory Equipment Orientation Checklist

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Patient/Caregiver Received:

☑ Written and Verbal Instructions ☑ Contact Number ☑ Supply Replenishment Information

Nebulizer or Heavy Duty Air Compressor:

Model:

- Explain How to Assemble All Nebulizer Parts
- Explain How to Attach All Nebulizer and Tubing to Compressor
- Explain Power on and Off and Settings (If Applicable)
- Explain How to Check for Proper Function and Troubleshooting Procedures
- Explain Disassembling for Cleaning and Maintenance
- Received Operating Manuals / Information Sheets

Oxygen: Is the patient prescribed oxygen equipment? ☑ Yes ☐ No

Model: **3B Medical STRATUS 5**

☑ Stationary Concentrator

☐ Portable Concentrator

☐ Self Fill Unit

- LPM **4** Via: **N/C** Hours of Use: **Continuous**
- Cylinder Size E
- Regular Care and Use: ☑ Continuous ☐ Conserver
- Power on/off, Setting flow as Prescribed
- Tank and/or Battery Duration Times
- No Smoking Sign, Audible Safety Alarms, and How to Respond
- Understands and Acknowledges Smoking and Hazards of Oxygen, and All Precautions
- Care, Change Frequency and Ordering of Disposables and Filters
- Safety: Grounded Outlets, No Extension Cords, Keep Well Ventilated, and No Oils or Liquids
- Operating Manuals/Information Sheets
- Troubleshooting, Safe Handling, Securing, Storage, and Travel
- How to Use Back-Up System(S)
- **If Patient Is a Smoker or Someone Who Lives in The Same Residence as The Patient Is a Smoker, Patient & Family Verbalize Dangers of Smoking While Using Oxygen, up to and Including Death and Destruction of Home. (E.G. No Smoking While Cannula Is On, No Lighted Materials or Sources of Ignition Located Within 7 Feet of All Oxygen Equipment.)**

PAP: Is the patient prescribed PAP Equipment? ☐ Yes ☑ No

Flow Generator: Mfg.: Model: Interface: Size: Settings:

Comfort: Flex: Ramp: CmH2o Minutes:

- General Operation and Care of Flow Generator, Humidifier, Filters, and Disposables
- Tubing, Mask/Headgear, Humidifier Disassemble and Re-Assemble
- Compliance Importance, Coaching, Monitoring and Requirements, Including Follow-Up with Physician
- Supply Replenishment
- Operation Manual/Information Sheets
- Monitoring Platform (Wireless Modem, Card Care and Removal)
- No Extension Cords
- Oxygen Safety Application Procedures, if applicable

Suction:

Model:

- Explain Setting Up: Collection Canister/Lid and Tubing, Adjust Vacuum Levels and Test for Proper Function
- Care and Use of Collection Canister/Lid and Disposables
- ☐ Battery Care/Duration (If Applicable)
- ☐ Troubleshooting
- Operation Manual/Information Sheet

Pulse Oximeter:

Model: Low Sat: % High HR: Low HR:

- Explain Power on And Off
- Alarm Parameters and How to Respond
- Battery Care, Use and Duration
- Troubleshooting
- Operation Manual/Information
- No Extension Cords
- Patient Cable and Probe, Care, Use and Placement

I, the undersigned, hereby acknowledge that I have received the information and instruction for my equipment. I am either the patient or a representative signing on behalf of the patient.

Signature	Relationship To Patient	Reason Beneficiary Could Not Sign
Michael Jones	Other: son in law	Not home
		Date Signed: 05/31/2024
Adapt Health Representative	Uhlrig, Gregg	Date Signed: 05/31/2024