Optimistic HealthCare Solutions

PATIENT SERVICE AGREEMENT

Patient Name: Kimberly Hofstede ID: 1EG4TE5MK73

Authorization/Consent for Care/Service: I have been informed of the home care options available to me and of the selection of providers from which I may choose. I authorize Optimistic Healthcare Solutions under the direction of the prescriber, to provide durable medical equipment, supplies and services as prescribed.

Assignment of Benefits/Authorization for Payment: I hereby assign all benefits and payments to be made directly to Optimistic Healthcare Solutions, for any durable medical equipment, supplies and services furnished to me in conjunction with my home care. I authorize Optimistic Healthcare Solutions to seek such benefits and payments on my behalf. It is understood that, as a courtesy. Optimistic Healthcare Solutions will bill Medicare/Medicaid or other federally funded sources and other payers and insurer(s) providing coverage, with a copy to Optimistic Healthcare Solutions I understand that I am responsible for providing all necessary information and for making sure all certification and enrolment requirements are fulfilled. Any changes in the policy must be reported to Optimistic Healthcare Solutions within 30 days of the event. I have been informed by Optimistic Healthcare Solutions of the medical necessity for the services prescribed. I understand that in the event services are deemed not reasonable and necessary, payment may be denied and that I will be fully responsible for payment.

Release of Information: I hereby request and authorize Optimistic Healthcare Solutions, the prescriber, hospital, and any other holder of information relevant to service, to release information upon request, to Optimistic Healthcare Solutions, any payer source, prescriber, or any other medical personnel or agency involved with service. I also authorize Optimistic Healthcare Solutions to review medical history and payer information for the purpose of providing home health care.

Financial Responsibility: I understand and agree that I am responsible for the payment of any and all sums that may become due for the services provided. These sums include, but are not limited to, all deductibles, co-payments, out-of-pocket requirements, and non-covered services. If for any reason and to any extent, Optimistic Healthcare Solutions does not receive payment from my payer source, I hereby agree to pay Optimistic Healthcare Solutions for the balance in full, within 30 days of receipt of invoice. All charges not paid within 45 days of billing date shall be assessed late charges. I am liable for all charges, including collection costs and all attorney's cost. I am responsible for all charges regardless of my payer unless my agreement with my health plan holds me harmless.

Kimberly **(Initials) I acknowledge that I have been advised of my financial responsibilities to Optimistic Healthcare Solutions**

Returned Goods: I understand that due to Federal and State Regulations ancillary items prescribed for home health care cannot be re-dispensed. Therefore, ancillary items cannot be returned for credit. Durable medical Equipment that is rented will be returned after the prescriber has discontinued service. Sale items cannot be returned. Optimistic Healthcare Solutions must be notified within 24 hours if any equipment is defective. In the case of defective equipment, an exchange will be made for the defective item.

Patient Handouts: ☐ I have received a copy of Patient Handouts that contains or ☐ I acknowledge that I have received a copy of the Patient Handouts which contains Patient Rights and Responsibilities, Supplier Standards, HIPAA Privacy Notice, Emergency Planning, Home Safety Information, Infection Control, Making Decisions About Your Health Care and Grievance / Complaint Reporting and Warranty Information.

- I acknowledge that the information in the Patient Handouts has been explained to me and that I understand the information.
- I acknowledge that I have received pharmacy marketing material and information on the pharmacy's scope of services.
- I acknowledge receipt of a product warranty on all applicable products. I acknowledge that I have been made aware of the specifics of the warranty including the duration, what is covered, owner's responsibilities for maintenance/care, and expenses involved in repair/replacement such as labor, shipping, or delivery.
- I acknowledge I have been made aware of the actions that may void a warranty, particularly if the product needs to be modified for any reason.

Complaint Reporting: I acknowledge that I have been informed of the procedure to report a complaint should I become dissatisfied with any portion of my home care experience. I understand that I may lodge a complaint without concern for reprisal, discrimination, or unreasonable interruption of service. To place a complaint, please call (281) 698-5119 and speak to customer services. If your complaint is not resolved to your satisfaction within 5 working days, you may initiate a formal complaint, in writing and forward it to the leadership. You can expect a written response within 14 working days of receipt.

You may also make inquiries or complaints about this pharmacy by calling Medicare at 1-800-MEDICARE, the Accreditation Commission for Health Care (ACHC) at (800) 656.9656 and/or the Texas State Board of Pharmacy at https://www.pharmacy.texas.gov/consumer/complaint.asp.

Patient: _____ Date: _____
(Patient or legal representative)

Witness: _____ Date: _____

Form Revised: 08/01/2023