AUTHORIZATION FOR RELEASE OF INFORMATION, ASSIGNMENT OF BENEFITS, DUPLICATE EQUIPMENT/SUPPLIES

Name_____

1. *Terms of Agreement*: I understand that by signing this agreement, I authorize provision of products or services to me by J&R Medical, Inc. I also understand that I am under the control of my attending physician and that J&R Medical is not liable for any act or omission when following the instructions of said physician.

2. *Medical Information Authorization*: I hereby authorize the use and disclosure of my health information to J&R Medical, Inc. including any records pertaining to my medical history, services rendered, or treatment. I understand that this authorization is voluntary and I may revoke this authorization at any time by notifying J&R Medical in writing, but if I do, it won't have any affect on any actions they took before they received the revocation.

   □ Progress Notes □ Laboratory/pathology records □ Other _____

3. *Assignment of Benefits*: I authorize direct payment to J&R Medical, Inc. of any insurance benefits for J&R Medical, Inc. provided products or services. I also authorize my insurance company(ies) to furnish to an agent of J&R Medical, Inc. any and all information pertaining to my insurance benefits and status of claims submitted by J&R Medical, Inc. for services rendered. I further authorize J&R Medical, Inc. to release to my insurance company(ies) any and all information pertaining to me for benefit determination.

4. *Financial Responsibility:* While there may be insurance coverage for those services or products provided by J&R Medical, Inc. to me relative to my medical supply needs, I recognize that all services may not be covered. I agree to be responsible for the charges for items which may not be covered by my state Medicaid program if I was advised prior to ordering or if my eligibility status changes. I understand that I am responsible for informing J&R Medical, Inc. of any changes in my eligibility or of any additional insurance coverage such as Medicare.

5. *Permission for Disclosure and Use of Information*: I agree to the release of my J&R Medical medical records to be reviewed by authorized representatives of Medicaid or any future insurance coverage that I obtain for use in determining my medical supply benefits.
   I understand that this authorization is voluntary and I may revoke this permission at any time by notifying J&R Medical in writing, but if I do, it won't have any affect on any actions they took before they received the revocation.

   I understand that I have the legal right to refuse the release of my personal and medical records now held by J&R Medical and that I am waiving this legal right by signing this consent. This consent shall be valid for whatever period of time is reasonably necessary for the individual/agency to review my records to determine my medical supply benefits.

_____ Initial Here

6. *Supplier Standards*: I have received, read and understand the Supplier Standards provided with this form.

7. *Returned Goods Policy*: All products provided by J&R Medical are warranted against defects. I understand that defective and incorrect supplies dispensed to me may be returned to J&R Medical for credit or replacement at no charge to me.

8. *Duplicate Equipment/Supplies:* Any company providing identical equipment/supplies to me has been notified and instructed to terminate further equipment/supply deliveries.

_____ Initial Here

9. *J&R Medical Notice of Privacy Practices*: I have received, read and understand the J&R Medical Notice of Privacy Practices

   This Agreement is considered ongoing for urological, incontinence and medical supplies

The undersigned certifies that he/she has read the foregoing, received a copy thereof, and if the patient, or is duly authorized by the patient as the patient's general agent to execute the above and accept its items.

_____ Beneficiary (or Parent/Guardian/Agent) Signature

_____ Date

_____ Relationship to Patient (if applicable)

_____ Reason Patient Unable to Sign (if applicable)

General Medical Records Release and Authorization for Use or Disclosure of Protected Health Information

Please complete the following information:

Patient Name: _____

Address: _____

_____

Phone: _____

SSN: _____Date of Birth:_____/_____/_____

I authorize the custodian of records of: _____or other person/entity (specifically describe) _____to disclose/release the following information* (check all applicable):

- ☐ All records
- ☐ X-ray/radiology records
- ☐ Abstract/Summary
- ☐ Other (describe specifically)
- ☐ Laboratory/pathology records
- ☐ Billing records
- ☐ Pharmacy/prescription records

These records are for services provided on the following date(s): _____

Please send the records listed above to (use additional sheets if necessary):

Name:	_____	Name:	_____
Address:	_____	Address:	_____
	_____		_____
Phone:	_____	Phone	_____
Fax:	_____	Fax:	_____

The information may be used/disclosed for each of the following purposes:

- ☐ At my request (only the patient can check this box)
- ☐ For my health care
- ☐ For payment/insurance
- ☐ For employment purposes
- ☐ Other:

This authorization shall expire no later than: ___/___/___ or upon the following event _____ (whichever is sooner). By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____

Signature of patient (or patient's personal representative) Date

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 and cannot contract with an individual or entity to provide licensed services.
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 its 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. This standard requires that the location is accessible to the public and staffed during posted hours of business. The location must be at least 200 square feet and contain space for storing records.
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 listed 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, answering service or cell phone during posted business hours 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 contacting a Medicare beneficiary based on a physician's oral order unless an exception applies.
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 maintain 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. A 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). *Implementation Date - October 1, 2009*
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.
26. Must meet the surety bond requirements specified in 42 C.F.R. 424.57(c). *Implementation date- May 4, 2009*
27. A supplier must obtain oxygen from a state- licensed oxygen supplier.
28. A supplier must maintain ordering and referring documentation consistent with provisions found in 42 C.F.R. 424.516(f).
29. DMEPOS suppliers are prohibited from sharing a practice location with certain other Medicare providers and suppliers.
30. DMEPOS suppliers must remain open to the public for a minimum of 30 hours per week with certain exceptions.

J&R MEDICAL
NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Promulgated Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO YOUR IDENTIFIABLE HEALTH INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our organization is dedicated to maintaining the privacy of your identifiable health information. In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and privacy practices concerning your identifiable health information. By law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

To summarize, this notice provides you with the following important information:

- How we may use and disclose your identifiable health information
- Your privacy rights in your identifiable health information
- Our obligations concerning the use and disclosure of your identifiable health information.

The terms of this notice apply to all records containing your identifiable health information that are created or retained by our practice. We reserve the right to revise or amend our notice of privacy practices. Any revision or amendment to this notice will be effective for all of your records our practice has created or maintained in the past, and for any of your records we may create or maintain in the future. Our organization will post a copy of our current notice in our offices in a prominent location, and you may request a copy of our most current notice during any office visit.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Compliance Officer, J&R MEDICAL, 4950 TERMINAL ST., SUITE 200 BELLAIRE, TX 77401 phone-713-344-0901

C. WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your identifiable health information:

1. **Treatment.** Our organization may use your identifiable health information to treat you. For example, we may perform a follow-up interview and we may use the results to help us modify your treatment plan. Many of the people who work for our organization may use of disclose your identifiable health information in order to treat you or to assist others in your treatment. Additionally, we may disclose your identifiable health information to others who may assist in your care, such as your physician, therapists, spouse, children, or parents.

2. **Payment.** Our organization may use and disclose your identifiable health information in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your identifiable health information to obtain payment from third parties who may be responsible for such costs, such as family members. Also, we may use your identifiable health information to bill you directly for services and items.

3. **Health Care Operations.** Our organization may use and disclose your identifiable health information to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our organization may use your health information to evaluate the quality of care you received from us or to conduct cost-management and business planning activities for our practice.

4. **Appointment Reminders.** Our organization may use and disclose your identifiable health information to contact you and remind you of visits/deliveries.

5. **Health-Related Benefits and Services.** Our organization may use and disclose your identifiable health information to inform you of health-related benefits or services that may be of interest to you.

6. **Release of Information to Family/Friends.** Our organization may release your identifiable health information to a friend or family member who is helping you pay for your health care of who assists in taking care of you.

7. **Disclosures Required By Law.** Our organization will use and disclose your identifiable health information when we are required to do so by federal, state, or local law.

D. USE AND DISCLOSURE OF YOUR IDENTIFIABLE HEALTH IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. **Public Health Risks.** Our organization may disclose your identifiable health information to public health authorities who are authorized by law to collect information for the purpose of :

   - Maintaining vital records, such as births and deaths
   - Reporting child abuse or neglect
   - Preventing or controlling disease, injury, or disability
   - Notifying a person regarding potential exposure to a communicable disease
   - Notifying a person regarding a potential risk for spreading or contracting a disease or condition
   - Reporting reactions to drugs or problems with products or devices
   - Notifying individuals if a product or device they may be using has been recalled
   - Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
   - Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. **Health Oversight Activities.** Our organization may disclose your identifiable health information to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure, and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws, and the health care system in general.

3. **Lawsuits and Similar Proceedings.** Our organization may use and disclose your identifiable health information in response to a court or administrative order if you are involved in a lawsuit or similar proceeding. We also may disclose your identifiable health information in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. **Law Enforcement.** We may release identifiable health information if asked to do so by a law enforcement official:
   - Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
   - Concerning a death we believe might have resulted from criminal conduct
   - Regarding criminal conduct at our offices
   - In response to a warrant, summons, court order, subpoena, or similar legal process
   - To identify/locate a suspect, material witness, fugitive, or missing person

- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

5. **Serious Threats to Health or Safety.** Our organization may use and disclose your identifiable health information when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

6. **Military.** Our organization may disclose your identifiable health information if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate military command authorities.

7. **National Security.** Our organization may disclose your identifiable health information to federal officials for intelligence and national security activities authorized by law. We also may disclose your identifiable health information to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

8. **Inmates.** Our organization may disclose your identifiable health information to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you; (b) for the safety and security of the institution; and/or (c) to protect your health and safety or the health and safety of other individuals.

9. **Workers' Compensation.** Our organization may release your identifiable health information for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR IDENTIFIABLE HEALTH INFORMATION

You have the following rights regarding the identifiable health information that we maintain about you:

1. **Confidential Communications.** You have the right to request that our organization communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to Compliance Officer, **,** J&R MEDICAL, 4950 TERMINAL ST., SUITE 200 BELLAIRE, TX 77401 specifying the requested method of contact or the location where you wish to be contacted. Our organization will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. **Requesting Restrictions.** You have the right to request a restriction in our use or disclosure of your identifiable health information for the treatment, payment, or health care operations. Additionally, you have the right to request that we limit our disclosure of your identifiable health information to individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request**; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use of disclosure of your identifiable health information, you must make your request in writing to Compliance Officer, **,** J&R MEDICAL, 4950 TERMINAL ST., SUITE 200 BELLAIRE, TX 77401. Your request must describe in a clear and concise fashion: (a) the information you wish restricted; (b) whether you are requesting to limit our practice's use, disclosure, or both; and (c) to whom you want the limits to apply.

3. **Inspection and Copies.** You have the right to inspect and obtain a copy of the identifiable health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing Compliance Officer, **,** J&R MEDICAL, 4950 TERMINAL ST., SUITE 200 BELLAIRE, TX in order to inspect and/or obtain a copy of your identifiable health information. Our organization may charge a fee for the costs of copying, mailing, labor, and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Reviews will be conducted by another licensed health care professional chosen by us.

4. **Amendment.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our organization. To request an amendment, your request must be made in writing and submitted to Compliance Officer, , J&R MEDICAL, 4950 TERMINAL ST., SUITE 200 BELLAIRE, TX 77401. You must provide us with a reason that supports your request for amendment. Our organization will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is: (a) accurate and complete; (b) not part of the identifiable health information kept by or for the organization; (c) not part of the identifiable health information which you would be permitted to inspect and copy; or (d) not created by our organization, unless the individual or entity that created the information is not available to amend the information.

5. **Accounting of Disclosures.** All of our patients have the right to requests an "accounting of disclosures." An "accounting of disclosures" is a list of certain disclosures our organization has made of your identifiable health information. In order to obtain an accounting of disclosures, you must submit your request in writing to Compliance Officer, J&R MEDICAL, 4950 TERMINAL ST., SUITE 200 BELLAIRE, TX 7740. All requests for an "accounting of disclosures" must state a time period which may not be longer than six years and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our organization will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. **Right to a Paper Copy of This Notice.** You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact Compliance Officer, **,** J&R MEDICAL, 4950 TERMINAL ST., SUITE 200 BELLAIRE, TX 77401.

7. **Right to File a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with our organization or with the Secretary of the Department of Health and Human Services. To file a complaint with our organization, Compliance Officer, , J&R MEDICAL, 4950 TERMINAL ST., SUITE 200 BELLAIRE, TX 77401. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

8. **Right to Provide an Authorization for Other Uses and Disclosures.** Our organization will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your identifiable health information may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your identifiable health information for the reasons described in the authorization. Please note that we are required to retain records of your care.

(USED WITH PERMISSION)