RESPICAIR P.C. PLAN OF SERVICE/INITIAL ASSESSMENT: GENERAL EQUIPMENT	Date of Delivery:_____ PPE: [ ] Gloves [ ] Mask [ ] Gown [ ] HEPA Mask
Patient: _____ Phone: _____ Address: _____ Emergency Contact: _____ Phone: _____ Order:	
FUNCTIONAL ASSESSMENT	**Pain:** [ ] No [ ] Yes If Yes, referred to:
Activities: [ ] Independent [ ] Homebound	**Ambulation:** [ ] Non-Ambulatory [ ] Normal [ ] Ambulates w/Assistance
Hearing: [ ] Normal [ ] Impaired [ ] Deaf [ ] Hearing Aid	**Sight:** [ ] Normal [ ] Blind [ ] Glasses/Contacts
Speech: [ ] Normal [ ] Impaired [ ] Mute [ ] Foreign Speaking	**Comments:**
Cultural/Religious Practices exists that may affect care or services. [ ] Yes [ ] No If Yes, describe:	
Ability to cope with current health status: [ ] Oriented [ ] Angry [ ] Frustrated [ ] Incoherent [ ] Forgetful [ ] Confused	Medications:
[ ] Caregiver [ ] Home health agency or hospice: Name and Number:	Caregiver/Patient Knowledge: [ ] Excellent [ ] Good [ ] Fair [ ] Poor
NUTRITIONAL STATUS: (Enteral feeding) If at risk, referred to: [ ] Normal [ ] High Risk	
HOME SAFETY ASSESSMENT	
Security: [ ] High Crime [ ] Security Guard [ ] Security System [ ] Vicious Dog [ ] OK [ ] Building Locked-Intercom/Buzzer	
Fire: [ ] Cluttered Pathways [ ] No Fire Extinguisher [ ] Smoker (in home) [ ] OK [ ] No Smoke Detector [ ] Improper Storage of Flammables	
Electrical: [ ] Unsafe use of Extension Cords [ ] Frayed Electrical Cords [ ] OK [ ] Overloaded Circuits [ ] Ungrounded Outlets	
Structural: [ ] Loose Handrails/No Handrails [ ] Narrow Doorways [ ] OK [ ] Loose Floorboards [ ] Carpet/Rugs Loose/Frayed	
Does equipment meet patient needs? [ ] Yes [ ] No	
Is further assessment needed? [ ] Yes [ ] No If Yes, describe: _____ Equipment Management/maintenance every: _____ days/months/years	
Equipment Management/Maintenance Every: days/months/years	
Community Referrals: [ ] Abuse Hotline [ ] Meals on Wheels [ ] Social Service [ ] Other (List below) Additional Concerns or Comments: Directions to Home:	
Employee Signature:	Date:

RespicAir,P.C.

Respiratory Care Services

PATIENT'S CONSENT FOR RECORDS RELEASE

I _____ give permission to RespicAir, P.C. office to release my records to the following: Please fill in which applies. Please note that this must be filled in or we are unable to furnish any information to any- all of the below who may request it.

Physician:_____

Physician:_____

Spouse:_____

Children:_____

Parent (Names):_____

Insurance Company:_____

Insurance Company:_____

Insurance Company:_____

OTHER _____

Print Patient Name:_____

Relationship:_____

Signature:_____

Date:_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from your insurance companies – third party payers.
- If payment is not received for services rendered we have the right to forward your bill without clinical information to a collection agency.
- Conduct normal healthcare operations such as quality assessments and respiratory clinical information.

Have received, read and understand your ***NOTICE OF PRIVACY PRACTICES*** containing a complete description of the uses and disclosures of my health information. I understand that this organization has the right to carry out treatment as directed by your physician (s). I understand that this organization has the right to change its ***NOTICE OF PRIVACY PRACTICES*** from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the ***NOTICE OF PRIVACY PRACTICES.***

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or other healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Print Patient Name:_____

Relationship:_____

Signature:_____

Date:_____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: Initials: Reason:

RespicAir,P.C.

Respiratory Care Services

Liability & Payment Authorization

Date: _____

_____1) Payment Liability: By signing this document of liability you are certifying that you are responsible for payment for services/equipment received. RespicAir will bill you for this co-payment. If your co-pay is not received in 60 days we will bill your credit card for the past due amount. I understand that if I do not pay for longer than 60 days, RespicAir may charge my credit card for unpaid balance or employ a collection agency and /or attorney to collect the payments. A collection rate of 33.5% may be applied.

2) Use of Equipment Liability: By signing this document you are certifying that you have been instructed in safe and proper use of this equipment. RespicAir Respiratory Therapy, P.C. assumes no liability if equipment is handled by persons who have not been properly instructed in its use. We are not liable for use of equipment other that it's intended use. We are not responsible for injuries/ and or property damages related to the improper use of said equipment by client or other persons. Any damages to rented equipment will the responsibility of the patient/client below. Repair costs will be billed to you. RespicAir, P.C. is not responsible for repairs not under warranty. Improper use of CPAP masks may result in facial soars. If soars related from the mask the patient must contact RespicAir and schedule an appointment for the mask to be properly re-fitted.

3) Payment Authorization: I request that payment of authorized Medicare/ Medicaid/ Private Insurance benefits be made to RespicAir, P.C Respiratory Therapy, P.C. on my behalf for services/equipment rendered. I authorize any holder of medical information about me to release to the Health Care Financing Administration (Medicare) or other insurance company and its agents any information needed to determine these benefits payable for related services. I understand that I am providing credit card authorization and information which will be used for Co-Pay or other past due bills only. I understand that I may be liable for a yearly deductible with my insurance carrier.

4) Capped Rentals: Certain items are capped after 10-13 months of rental, at this time equipment ownership transfers to the patient. If a certificate of ownership is required the patient can call to obtain one. All expenses after ownership transfer including repairs or replacement are the sole responsibility of the owner.

5)Post Capped Fees: You will be charged additional fees for service after the equipment is transferred to you. These fees will be billed directly to you, not to your insurance provider.

For any Durable Medical Equipment Please sign below that you have not received it within the last 5 years through your present insurance company

Disclaimer: If you have for instance received oxygen with another provider you may be responsible for payment for the equipment with RespicAir, P.C. All Ventilators and Oxygen Concentrators are under rental contracts and MUST be returned to RespicAir, P.C.

I am authorizing this card to be charged by RespicAir, P.C. in the event of non- payment or co-pay as stated in the terms above.

CREDIT CARD: MASTERCARD OR VISA Pt has signed up with monthly copay billing for _____ months.
CREDIT CARD #: _____
CREDIT CARD EXPIRATION DATE: _____
3 DIGIT CODE ON SIGNATURE LINE: _____
Print Name: _____

Signed: _____

Company Representative: _____

RESPICAIR RESPIRATORY THERAPY, PC
CUSTOMER ORIENTATION FORM

Please check each item that has been provided to the patient and reviewed:

_____ My rights and responsibilities as a customer.

_____ My financial responsibilities.

_____ My Communications Form and hot line number to report an infraction of my rights.

_____ A Consumer Satisfaction or Perception of Care Survey to report a concern or share a compliment.

_____ My Delivery Ticket denoting equipment and/or products delivered.

_____ My Release of Information/Assignment of Benefits.

_____ The safe environment of my home and its suitability to the equipment and/or products delivered.

_____ The safe and proper operation of the equipment and/or products delivered.

_____ Equipment and supply cleaning procedures.

_____ Product warranty information and maintenance requirements.

_____ Important RespicAir Respiratory Therapy, PC telephone numbers, including after-hours information.

_____ Received information regarding Emergency Preparedness.

_____ Received information regarding Advance Directives and Resuscitation.

_____ Medicare Supplier Standards.

_____ HIPAA Privacy Notice.

_____ I have been given a copy of RespicAir Pc's organization objectives outlining all equipment and services. I am also aware that I can find a copy on RespicAir PC's website at www.Respicairpc.com.

_____ I understand that Insurance yearly deductibles are my responsibility I will check with my insurance carrier for the amount.

_____ Other_____

My signature attests that I have received, read, and/or been instructed, in detail, on the above check information:

_____
Customer Signature & Date

_____
RespicAir Respiratory Therapy, PC Representative Date

RespicAir PC

Respiratory Care Services

HIPAA NOTICE

WHAT INFORMATION IS PROTECTED?

- Information your doctors, nurses, and other health care providers put in your medical record.
- Conversations your doctor has about your care or treatment with nurses and others.
- Information about you in your health insurer's computer system
- Billing information about you at your clinic
- Most other health information about you held by those who must follow this law.

HOW IS THIS INFORMATION PROTECTED?

- Respicair has safeguards to protect your health information.
- Respicair reasonably limits uses and disclosures to the minimum necessary to accomplish their intended purpose.
- Respicair has contracts in place with our contractors and others ensuring that they use and disclose your health information properly and safeguard it appropriately.
- Respicair has procedures in place to limit who can view and access your health information as well as implement training programs for our employees about how to protect your health information.

WHAT RIGHTS DOES THE PATIENT HAVE?

- Ask to see and get a copy of your health records.
- Have corrections added to your health information
- Receive a notice that tells you how your health information may be used and shared.
- Decide if you want to give your permission before your health information can be used or shared for certain purposes, such as for marketing.
- Get a report on when and why your health information was shared for certain purposes.
- If you believe your rights are being denied or your health information is not being protected, you can.
    - File a complaint with your provider or health insurer.
    - File a complaint with the U.S. Government

RespicAir PC

Respiratory Care Services

766 Main Street

Niagara Falls, N.Y. 14301
716-278-0204

Dear Valued RespicAir, PC Clients:

We are currently asking all new and current patients to answer a few quick questions. This will help us to streamline your respiratory care, and continue to provide you with the highest quality equipment available. Remember that we are a local company and want the business to stay local. Don't use a National company!

- Do you or anyone else in your household use any Other Respiratory Equipment? That is supplied by someone else, other than RespicAir, PC. Like a BIPAP, or CPAP, nebulizer or oxygen. We can help.

- Can you let us know if you or friend or relative need any Respiratory Equipment? RespicAir, PC is your local Respiratory care provider. We do regular deliveries throughout Niagara and Erie counties each day! Our staff and Respiratory Therapists are here to answer your questions and help you with all your equipment needs. Along with excellent Customer Service and Billing and Insurance questions or help.

- If you refer a friend or relative to us and are a CPAP, BIPAP or BIPAP ST Client then you are eligible for free CPAP/BIPAP mask wipes, chin strap or a free pair of nasal pillows. Medicare patients are not applicable.

Either write their name below and their phone number or call us! (Please check with the person to let them know you are giving out their information.)

Your name:_____

Your phone number:_____

New Referral Name:_____

New referral Phone number:_____

RespicAir PC

Respiratory Care Services

We will replace any defective or malfunctioning equipment under the manufacturer's warranty. We will continue to provide properly functioning equipment under current Medicare guidelines to all patients.