

TERMS, CONDITIONS, & RESPONSIBILITIES (TCR)

Patient/Customer Name: _____ Account Code: _____ State: _____

1. AUTHORIZATION & ASSIGNMENT OF BENEFITS

I authorize Advanced Respiratory, Inc., a Hill-Rom company (including its affiliates and subsidiaries) (Advanced Respiratory) to submit insurance claims for The Vest® Airway Clearance System according to the terms of my prescription. I request that payment of authorized benefits be made on my behalf directly to Advanced Respiratory, for any items or services furnished to me by Advanced Respiratory.

Advanced Respiratory will be accepting assignment from payor(s) unless the box below is checked.

Will Not Accept Assignment

2. RELEASE OF MEDICAL INFORMATION / AUTHORIZATION OF THIRD PARTY PAYMENT

I authorize Advanced Respiratory and/or any holder of medical information about me to release to the Medicare program or other third party payers any information needed to determine payment of authorized benefits until all benefits associated with Advanced Respiratory products have been paid. I further agree that Advanced Respiratory as a covered entity, its employees and agents, and accrediting and governmental agencies may access, request and receive from other healthcare providers involved in my care, and use/disclose my medical information for the purposes of: obtaining/substantiating payment for products/services provided, providing Advanced Respiratory products and services, reviewing and assessing the use of Advanced Respiratory products and services, administering the business operations of Advanced Respiratory, and protecting the safety of Advanced Respiratory employees and agents.

3. FINANCIAL RESPONSIBILITY

I understand I am responsible for any amounts not covered by my insurance including any applicable co-payments and deductibles, subject to the rules of my insurance. I am responsible for returning all rental equipment to Advanced Respiratory if I fail to make acceptable financial arrangements, if I stop using the equipment, if my doctor discontinues the order for this equipment, or if I no longer qualify for the product(s) in accordance with my payer's guidelines and I fail to make acceptable financial arrangements. I will contact Advanced Respiratory Customer Service at 800-426-4224 to coordinate pick-up of rental equipment at no cost to me.

I also understand that "any amount not covered by my insurance" cannot be determined until insurance requests, including appeals, if applicable, have been completed and I have been notified. I understand that I must cooperate with Advanced Respiratory, in order to keep The Vest® Airway Clearance System.

By signing this I agree to all of the terms and conditions listed above.

Signature of Patient or Patient's Authorized Representative:

X _____
Signature

Date: _____
(MM/DD/YY)

Authorized Representative's Relationship to Patient and Address: **(Required when Authorized Representative is signing)**

Relationship

Address

Check reason patient unable to sign:

- Patient/customer is under 18. (However, if the patient is 18 or over but covered under their parent's insurance, the parent should sign as the authorized representative).
- Patient/customer is physically or mentally unable to sign on their own behalf.
- Other: _____.

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ADDITIONAL NOTIFICATIONS FOR RESIDENTS OF MAINE

The person signing this authorization may receive a copy of this authorization.

A patient may refuse authorization to disclose some or all health care information, but that refusal may result in improper diagnosis or treatment, or denial of coverage of a claim for health benefits or other insurance.

This authorization may be revoked at any time, subject to the right of the person acting in reliance on the authorization to use such revocation as the basis for denial of coverage.

ADDITIONAL NOTIFICATIONS FOR RESIDENTS OF RHODE ISLAND

The person signing this authorization may receive a copy of this authorization.

Consent may be withdrawn at any time except where an authorization is executed in connection with a claim for benefits, and if so the authorization is valid for the duration of the claim.

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- By accepting this product and any replacement products which may be provided, you (patient/caregiver/legal guardian) are representing that you understand and acknowledge that your payer, including certain government payers, may eventually require ownership of the product to be transferred to the payer from which payment was received. In such cases, we may need to (re)enter the home to perform certain tasks related to title transfer activities. By accepting the product, you agree to comply with all such requirements and to grant access to the home as needed. Please contact your payer if you have questions regarding transfer of product ownership

Advanced Respiratory's Reimbursement Department will work with you/your dependent's insurance company to obtain coverage for The Vest[®] Airway Clearance System. As part of the insurance authorization process we need to have your signature acknowledging the Terms, Conditions, & Responsibilities contained within. The form has three parts:

- **Assignment of Benefits:** This section gives the insurance company your permission to send payments directly to Advanced Respiratory, a Hill-Rom company.
- **Release of Medical Information:** This Section gives us your permission to use appropriate health information to pursue authorization or payment from your insurance company. For information regarding your Rights concerning the use and disclosure of your health information, please refer to the Hill-Rom Notice of Privacy Practices provided to you in the packet of "Important Information from The Vest[®] Airway Clearance System".
- **Financial Responsibility:** This section outlines your responsibilities:
 - 1) To make "acceptable" financial arrangements for amounts not paid by insurance. "Acceptable" is determined on a case-by-case basis and generally cannot be determined until *after* insurance options are exhausted. Frequently this means pursuing insurance appeals;

and
 - 2) To make arrangements with Advanced Respiratory to return The Vest[®] Airway Clearance System upon termination of use or if the doctor discontinues the prescription (rental only).

❖ Signature guidelines for Advanced Respiratory, Inc employees and Contracted Trainers only

- Advanced Respiratory, Inc., employees/Contracted Trainers may **NOT sign** someone else's name – **even with permission**. This includes "**stamping**" a patient's signature with a signature stamp.
- Advanced Respiratory, Inc., employees/Contracted Trainers may **NOT date** another person's signature – **even with permission**.
- **Signature stamps & "Mark" (X)**
 - Advanced Respiratory Employee/Contract Trainer may **NOT** stamp the signature or "Mark" (X) for the patient.
 - **If signature stamp is used:**
 - Employee/Trainer writes a note: "patient stamped own signature on _____ (fill in date), then sign and date.
 - Insured OR Authorized Representative would stamp patient's signature. That person would then write out the following information: Their Name, relationship to the patient, address, and reason the patient can't sign.
 - **If signing with a "Mark" (X):**
 - A patient may sign with an "X" if he/she is unable to write his/her name. Two witnesses must certify use of the "Mark" by their signature and date. One of these witnesses may be an Advanced Respiratory, Inc., employee/contracted trainer.
 - The second witness (non ARI employee/Trainer) must sign & write his/her address & date.

When you have completed this form, please either return it directly to Advanced Respiratory, or to a member of your health care team, who will then return it to Advanced Respiratory, Inc.

Please fax the front of this form to: 1-800-870-8452