8053 Airway Park Dr
Mobile, AL 36608
Phone: (251) 338-8051
Fax: (251) 650-4498
www.portcitymedical.com

Dear New Patient,

Welcome and thank you for choosing Port City Medical, LLC for your home healthcare needs!
Enclosed in this packet you will find the following documents:

*** THESE DOCUMENTS *MUST* BE COMPLETED, SIGNED AND *RETURNED* TO Port City Medical, LLC:**

Patient's Rights and Responsibilities *****
Patient Agreement *****
Patient Information Release *****
Patient Acknowledgement of Receipt *****
Scope of Services *****

PLEASE RETAIN THESE DOCUMENTS FOR YOUR RECORDS:

DMEPOS Medicare Supplier Standards
Notice of Privacy Practices
Patient Complaint/Grievances Policy
Billing and Reimbursement Practices
Emergency Policies & Procedures for Patients

Please complete and sign the Patient's Rights and Responsibilities, Patient Agreement, Patient Information Release, Delivery Authorization, and Patient Acknowledgement of Receipt documents at your earliest convenience and return them to us in the enclosed self-addressed, stamped envelope.
Please note that these forms need to be on file with our office before we can deliver your supplies.

In the future, if there are any changes to your contact information, address, insurance or doctors, please update Port City Medical, LLC *immediately*.
We pride ourselves on our outstanding customer service, products and deliveries. Please contact us with any questions or comments about your supply needs or service. Take a moment to browse our website: www.portcitymedical.com to see our full product offerings.
Thank you for choosing Port City Medical, LLC. We look forward to working with you!

Sincerely,
Port City Medical, LLC

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MEDICARE DMEPOS SUPPLIER STANDARDS

Port City Medical **adheres to the following standards as required by the Centers for Medicare and Medicaid Service:**

1. A supplier must be in compliance with all applicable Federal and State licensure and regulatory requirements.
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.
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 mobile communications devices 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 calling beneficiaries in order to solicit new business.
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, 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 of DMEPOS and other items and services 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 for those specific products and services
23. All DMEPOS suppliers must notify their accreditation organization when a new DMEPOS location is opened. The accreditation organization may accredit the new supplier location for 3 months after it is operational without requiring a new site visit.
24. All DMEPOS supplier locations, whether owned or subcontracted, must meet the DMEPOS quality standards and be separately accredited in order to bill Medicare. An accredited supplier may be denied enrollment or their enrollment may be revoked, if CMS determines that they are not in compliance with the DMEPOS quality standards.
25. All DMEPOS suppliers must disclose upon enrollment all products and services, including the addition of new product lines for which they are seeking accreditation. If a new product line is added after enrollment, the DMEPOS supplier will be responsible for notifying the accrediting body of the new product so that the DMEPOS supplier can be re-surveyed and accredited for these new products.
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.

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PATIENT BILL OF RIGHTS AND RESPONSIBILITIES

We believe that all patients receiving services from Port City Medical should be informed of their rights. Therefore, you are entitled to:

1. Be fully informed in advance about care/service to be provided, including the disciplines that furnish care and the frequency of visits, as well as any modifications to the plan of care
2. Be informed, both orally and in writing, in advance of care being provided, of the charges, including payment for care/service expected from third parties and any charges for which the client/patient will be responsible
3. Receive information about the scope of services that the organization will provide and specific limitations on those services
4. Participate in the development and periodic revision of the plan of care
5. Refuse care or treatment after the consequences of refusing care or treatment are fully presented
6. Be informed of client/patient rights under state law to formulate an Advanced Directive, if applicable
7. Have one's property and person treated with respect, consideration, and recognition of client/patient dignity and individuality
8. Be able to identify visiting personnel members through proper identification
9. Be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of client/patient property
10. Voice grievances/complaints regarding treatment or care, lack of respect of property or recommend changes in policy, personnel, or care/service without restraint, interference, coercion, discrimination, or reprisal
11. Have grievances/complaints regarding treatment or care that is (or fails to be) furnished, or lack of respect of property investigated
12. Confidentiality and privacy of all information contained in the client/patient record and of Protected Health Information
13. Be advised on agency's policies and procedures regarding the disclosure of clinical records
14. Choose a health care provider, including choosing an attending physician, if applicable
15. Receive appropriate care without discrimination in accordance with physician orders, if applicable
16. Be informed of any financial benefits when referred to an organization
17. Be fully informed of one's responsibilities

PATIENT RESPONSIBILITIES

1. Patient agrees that rental equipment will be used with reasonable care, not altered or modified, and returned in good condition (normal wear and tear excepted).
2. Patient agrees to promptly report to Port City Medical any malfunctions or defects in rental equipment so that repair/ replacement can be arranged.
3. Patient agrees to provide Port City Medical access to all rental equipment for repair/replacement, maintenance, and/or pick-up of the equipment.

4 Patient agrees to use the equipment for the purposes so indicated and in compliance with the physician's prescription.
5 Patient agrees to keep the equipment in their possession and at the address, to which it was delivered unless otherwise authorized by Port City Medical
6 Patient agrees to notify Port City Medical of any hospitalization, change in customer insurance, address, telephone number, physician, or when the medical need for the rental equipment no longer exists.
7 Patient agrees to request payment of authorized Medicare, Medicaid, or other private insurance benefits are paid directly to Port City Medical for any services furnished by Port City Medical.
8 Patient agrees to accept all financial responsibility for home medical equipment furnished by Port City Medical
9 Patient agrees to pay for the replacement cost of any equipment damaged, destroyed, or lost due to misuse, abuse or neglect.
10 Patient agrees not to modify the rental equipment without the prior consent of Port City Medical
11 Patient agrees that any authorized modification shall belong to the titleholder of the equipment unless equipment is purchased and paid for in full.
12 Patient agrees that title to the rental equipment and all parts shall remain with Port City Medical at all times unless equipment is purchased and paid for in full.
13 Patient agrees that Port City Medical shall not insure or be responsible to the patient for any personal injury or property damage related to any equipment; including that caused by use or improper functioning of the equipment; the act or omission of any other third party, or by any criminal act or activity, war, riot, insurrection, fire or act of God
14 Patient understands that Port City Medical retains the right to refuse delivery of service to any patient at any time.
15 Patient agrees that any legal fees resulting from a disagreement between the parties shall be borne by the unsuccessful party in any legal action taken.

When the patient is unable to make medical or other decisions, the family should be consulted for direction.

All staff members will understand and be able to discuss the Patient Bill of Rights and Responsibilities with the patient and caregiver(s). Each staff member will receive training during orientation and attend an annual in-service education class on the Patient Bill of Rights and Responsibilities.

The patient and caregiver(s) will also receive a copy of the DMEPOS Supplier Standards, which is included in the Patient Handouts forms.

P A T I E N T C O P Y

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PATIENT COMPLAINTS/GRIEVANCES POLICY

Patients/clients and caregivers have the right to have all complaints heard, investigated and whenever possible, resolved. Port City Medical, LLC promotes open communication between patients/parents/guardians and staff. The Company respects both the patients' rights and the need for effective communication.

Patients/clients are free to voice complaints or grievances regarding policies or services and recommend changes without coercion, discrimination, reprisal or unreasonable interruption of services. The complaint process includes intake, investigation, corrective action as applicable, complaint resolution, and follow-up. Patients receive required documentation about The Company's complaint-resolution process within their intake documentation.

You may lodge a complaint without concern for reprisal, discrimination, or unreasonable interruption of service. To place a grievance, please call 251-338-8051 and speak to the Customer Services Supervisor. If your complaint is not resolved to your satisfaction within 5 working days, you may initiate a formal grievance in writing and forward it to the Governing Body. You can expect a written response within 14 working days or receipt.

You may also make inquiries or complaints about this company by calling your local Social Services Department, Medicare at 1-800-MEDICARE and/or the Accreditation Commission for Health Care (ACHC) at 919-785-1214.

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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 MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR COMMITMENT TO YOUR PRIVACY

It is our duty to maintain the privacy and confidentiality of your protected health information (PHI). We will create records regarding your and the treatment and service we provide to you. We are required by law to maintain the privacy of your PHI, which includes any individually identifiable information that we obtain from you or others that relates to your past, present or future physical or mental health, the health care you have received, or payment for your health care. We will share protected health information with one another, as necessary, to carry out treatment, payment or health care operations relating to the services to be rendered at the Pharmacy.

As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of PHI. This notice also discusses the uses and disclosures we will make of your PHI. We must comply with the provisions of this notice as currently in effect, although we reserve the right to change the terms of this notice from time to time and to make the revised notice effective for all PHI we maintain. You can always request a written copy of our most current privacy notice from our Privacy Officer.

PERMITTED USES AND DISCLOSURES

We can use or disclose your PHI for purposes of treatment, payment and health care operations. For each of these categories of uses and disclosures, we have provided a description and an example below. However, not every particular use or disclosure in every category will be listed.

- Treatment means providing services as ordered by your physician. Treatment also includes coordination and consultations with other health care providers relating to your care and referrals for health care from one health care provider to another. We may also disclose PHI to outside entitles performing other services related to your treatment such as hospital, diagnostic laboratories, home health or hospice agencies, etc.
- Payment means the activities we undertake to obtain reimbursement for the health care provided to you, including billing, collections, claims management, prior approval, determinations of eligibility and coverage and other utilization review activities. Federal or state law may require us to obtain a written release from you prior to disclosing certain specially protected PHI for payment purposes, and we will ask you to sign a release when necessary under applicable law.
- Health care operations means the support functions of the Pharmacy, related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient comments and complaints, physician reviews, compliance programs, audits, business planning, development, management and administrative activities. We may use your PHI to evaluate the performance of our staff when caring for you. We may also combine PHI about many patients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose PHI for review and learning purposes. In addition, we may remove information that identifies you so that others can use the de-identified information to study health care and health care delivery without learning who you are.

OTHER USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

We may also use your PHI in the following ways:

- To provide appointment reminders for treatment or medical care.
- To tell you about or recommend possible treatment alternatives or other health-related benefits and services that may be of interest to you.
- To disclose to your family or friends or any other individual identified by you to the extent directly related to such person's involvement in your care or the payment for your care. We may use or disclose your PHI to notify, or assist in the notification of, a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. If you are available, we will give you an opportunity to object to these disclosures, and we will not make these disclosures if you object. If you are not available, we will determine whether a disclosure to your family or friends is in your best interest, taking into account the circumstances and based upon our professional judgment.
- When permitted by law, we may coordinate our uses and disclosures of PHI with public or private entities authorized by law or by charter to assist in disaster relief efforts.
- We will allow your family and friends to act on your behalf to pickup filled prescriptions, medical supplies, X-rays, and similar forms of PHI, when we determine, in our professional judgment, that it is in your best interest to make such disclosures.

We may contact you as part of our fundraising and marketing efforts as permitted by applicable law. You have the right to opt out of receiving such fundraising communications.

- We may use or disclose your PHI for research purposes, subject to the requirements of applicable law. For example, a research project may involve comparisons of the health and recovery of all patients who received a particular medication. All research projects are subject to a special approval process which balances research needs with a patient's need for privacy. When required, we will obtain a written authorization from you prior to using your health information for research.
- We will use or disclose PHI about you when required to do so by applicable law.
- In accordance with applicable law, we may disclose your PHI to your employer if we are retained to conduct an evaluation relating to medical surveillance of your workplace or to evaluate whether you have a work-related illness or injury. You will be notified of these disclosures by your employer or the Pharmacy as required by applicable law.

Note: incidental uses and disclosures of PHI sometimes occur and are not considered to be a violation of your rights. Incidental uses and disclosures are by-products of otherwise permitted uses or disclosures which are limited in nature and cannot be reasonably prevented.

SPECIAL SITUATIONS

Subject to the requirements of applicable law, we will make the following uses and disclosures of your PHI:

- Organ and Tissue Donation. If you are an organ donor, we may release PHI to organizations that handle organ procurement or transplantation as necessary to facilitate organ or tissue donation and transplantation.
- Military and Veterans. If you are a member of the Armed Forces, we may release PHI about you as required by military command authorities. We may also release PHI about foreign military personnel to the appropriate foreign military authority.
- Worker's Compensation. We may release PHI about you for programs that provide benefits for work-related injuries or illnesses.
- Public Health Activities. We may disclose PHI about you for public health activities, including disclosures:
    - to prevent or control disease, injury or disability;
    - to report births and deaths;
    - to report child abuse or neglect;
    - to persons subject to the jurisdiction of the Food and Drug Administration (FDA) for activities related to the quality, safety, or effectiveness of FDA-regulated products or services and to report reactions to medications or problems with products;
    - to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
    - to notify the appropriate government authority if we believe that an adult patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if the patient agrees or when required or authorized by law.
- Health Oversight Activities. We may disclose PHI to federal or state agencies that oversee our activities (e.g., providing health care, seeking payment, and civil rights).
- Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose PHI subject to certain limitations.
- Law Enforcement. We may release PHI if asked to do so by a law enforcement official:
    - In response to a court order, warrant, summons or similar process;
    - To identify or locate a suspect, fugitive, material witness, or missing person;
    - About the victim of a crime under certain limited circumstances;
    - About a death we believe may be the result of criminal conduct;
    - About criminal conduct on our premises; or
    - In emergency circumstances, to report a crime, the location of the crime or the victims, or the identity, description or location of the person who committed the crime.

* Coroners, Medical Examiners and Funeral Directors. We may release PHI to a coroner or medical examiner. We may also release PHI about patients to funeral directors as necessary to carry out their duties. National Security and Intelligence Activities. We may release PHI about you to authorized federal officials for intelligence, counterintelligence, other national security activities authorized by law or to authorized federal officials so they may provide protection to the President or foreign heads of state.
* Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release PHI about you to the correctional institution or law enforcement official. This release would be necessary (1) to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
* Serious Threats. As permitted by applicable law and standards of ethical conduct, we may use and disclose PHI if we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public or is necessary for law enforcement authorities to identify or apprehend an individual.

Note: HIV-related information, genetic information, alcohol and/or substance abuse records, mental health records and other specially protected health information may enjoy certain special confidentiality protections under applicable state and federal law. Any disclosures of these types of records will be subject to these special protections.

OTHER USES OF YOUR HEALTH INFORMATION

Certain uses and disclosures of PHI will be made only with your written authorization, including uses and/or disclosures: (a) of psychotherapy notes (where appropriate); (b) for marketing purposes; and (c) that constitute a sale of PHI under the Privacy Rule. Other uses and disclosures of PHI not covered by this notice or the laws that apply to us will be made only with your written authorization. You have the right to revoke that authorization at any time, provided that the revocation is in writing, except to the extent that we already have taken action in reliance on your authorization.

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BILLING AND REIMBURSEMENT PRACTICES

Our mission at Port City Medical, LLC is to offer our clients outstanding service and simplify the way that medical supplies are ordered and received. Port City Medical, LLC manages all of the requirements associated with ordering supplies under Medicare, Medicaid, Blue Cross Blue Shield and other insurance plans for clients, such as obtaining prescriptions, letters of medical necessity and insurance prior approvals, if required. Our client service representatives help clients determine their insurance coverage and bill the insurance(s) on their behalf. By signing the *Patient Agreement*, the client authorizes Port City Medical, LLC to request on their behalf, and to collect directly, all public and private insurance coverage benefits due for products and services supplied by The Company. In the event payments for insurance benefits are made directly to the client, they agree to accept all responsibility for payments due.

Deliveries are made, as requested by the client, until the item(s) are no longer medically necessary, and/or the client is deemed ineligible to receive the supplies.

One day prior to the scheduled delivery, the clients' insurance eligibility is verified to ensure coverage for products to be delivered. **If the client is deemed *ineligible* for the date of service, the supplies requested *CANNOT* be delivered.** However**,** deliveries may resume as soon as the client is determined to be eligible again.

Direct Pay: If you request an item or supply which is deemed 'non- covered' by your insurance, it will be required to be paid for *prior to delivery*. We accept MasterCard, Visa, Discover, and American Express.

RETURNED GOODS POLICY
Products delivered to clients may be returned if the product is defective, the incorrect product or quantity of product, or any other acceptable reason- as determined by Management.

Any products presented for return will *not* be accepted unless they are in the *original* package and *unused* and *unopened*. We cannot accept returns of any items that have been used on or next to the skin.

The product return/pick up arrangement must be made by the client with Customer Service as soon as possible.

***The products* must *be in unused condition; otherwise the client shall be responsible for the cost of the products.* The client agrees to inform Charm Medical Supply whenever there are any changes to residence, physician, insurance carrier or prescription. Failure to notify Charm Medical Supply may result in the client being responsible for 100% of the charges for the supplies which were delivered.**

INSURANCES COVERED

Medicare, Medicaid, BC/BS of AL, Ambetter of AL, Humana, Viva health, Wellcare, UHC PPO, Tricare South

** IF YOU DO NOT SEE YOUR INSURANCE LISTED HERE, PLEASE CALL CUSTOMER SERVICE AT 251-338-8051 FOR MORE INFORMATION. SOME EXCEPTIONS MAY APPLY.*

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EMERGENCY POLICIES & PROCEDURES *FOR PATIENTS*

This pamphlet has been provided by Port City Medical to help you plan your actions in case there is a natural disaster where you live. Many areas of the United States are prone to natural disasters like hurricanes, tornadoes, floods, and earthquakes.

Every patient receiving care or services in the home should think about what they would do in the event of an emergency. Our goal is to help you plan so that we can try to provide you with the best, most consistent service we can during the emergency.

Know What to Expect

If you have recently moved to this area, take the time to find out what types of natural emergencies have occurred in the past, and what types might be expected.

Find out what, if any, time of year these emergencies are more prevalent.

Find out when you should evacuate, and when you shouldn't.

Your local Red Cross, local law enforcement agencies, local news and radio stations usually provide excellent information and tips for planning.

Know Where to Go

One of the most important pieces of information you should know is the location of the closest emergency shelter.

These shelters are opened to the public during voluntary and mandatory evaluation times. They are usually the safest place for you to go, other than a friend or relative's home in an unaffected area.

Know What to Take with You

If you are going to a shelter, there will be restrictions on what items you can bring with you. Not all shelters have adequate storage facilities for medications that need refrigeration.

We recommend that you call ahead and find out which shelter in your area will let you bring your medications and medical supplies, in addition, let them know if you will be using medical equipment that requires an electrical outlet.

During our planning for a natural emergency, we will contact you and deliver, if possible, at least one week's worth of medication and supplies. Bring all your medications and supplies with you to the shelter.

Reaching Us if There Are No Phones

How do you reach us during a natural emergency if the phone lines don't work? How would you contact us? If there is warning of the emergency, such as a hurricane watch, we will make every attempt to contact you and provide you with the number of our cellular phone. (Cellular phones frequently work even when the regular land phone lines do not.)

If you have no way to call our cellular phone, you can try to reach us by having someone you know call us from his or her cellular phone. (Many times cellular phone companies set up communication centers during natural disasters. If one is set up in your area, you can ask them to contact us.)

If the emergency was unforeseen, we will try to locate you by visiting your home, or by contacting your home nursing agency. If travel is restricted due to damage from the emergency, we will try to contact you through local law enforcement agencies.

An Ounce of Prevention...
We would much rather prepare you for an emergency ahead of time than wait until it has happened and then send you the supplies you need.

To do this, we need for you to give us as much information as possible before the emergency. We may ask you for the name and phone number of a close family member, or a close friend or neighbor. We may ask you where you will go if an emergency occurs. Will you go to a shelter, or a relative's home? If your doctor has instructed you to go to a hospital, which one is it?

Having the address of your evacuation site, if it is in another city, may allow us to service your therapy needs through another company.

Helpful Tips

- Get a cooler and ice or freezer gel-packs to transport your medication.
- Get all of your medication information and teaching modules together and take them with you if you evacuate.
- Pack one week's worth of supplies in a plastic-lined box or waterproof tote bag or tote box. Make sure the seal is watertight.
- Make sure to put antibacterial soap and paper towels into your supply kit.
- If possible, get waterless hand disinfectant from Port City Medical or from a local store. It comes in very handy if you don't have running water.
- If you are going to a friend or relative's home during evacuation, leave their phone number and address with Port City Medical and your home nursing agency.
- When you return to your home, contact your home nursing agency and Port City Medical so we can visit and see what supplies you need.

For More information

There is much more to know about planning for and surviving during a natural emergency or disaster. Review the information form FEMA
http://www.fema.gov/areyouready/emergency_planning.shtm. The information includes:

- Get informed about hazards and emergencies that may affect you and your family.
- Develop an emergency plan.
- Collect and assemble disaster supplies kit , which should include:
    - Three-day supply of non-perishable food.
    - Three-day supply of water - one gallon of water per person, per day.
    - Portable, battery-powered radio or television and extra batteries.
    - Flashlight and extra batteries.
    - First aid kit and manual.
    - Sanitation and hygiene items (moist towelettes and toilet paper).
    - Matches and waterproof container.
    - Whistle.
    - Extra clothing.
    - Kitchen accessories and cooking utensils, including a can opener.
    - Photocopies of credit and identification cards.
    - Cash and coins.
    - Special needs items, such as prescription medications, eye glasses, contact lens solutions, and hearing aid batteries.
    - Items for infants, such as formula, diapers, bottles, and pacifiers.
    - Other items to meet your unique family needs.
- Learn where to seek shelter from all types of hazards.
- Identify the community warning systems and evacuation routes.
- Include in your plan required information from community and school plans.
- Learn what to do for specific hazards. · Practice and maintain your plan.

An Important Reminder!!

During any emergency situation, if you are unable to contact our company and you are in need of your prescribed medication, equipment or supplies, ***you must go to the nearest emergency room or other treatment facility for treatment.***

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IMPORTANT MESSAGE TO OUR VALUED CLIENTS & CAREGIVERS

PLEASE REMEMBER THE FOLLOWING IS REQUIRED FOR EACH MONTHLY DELIVERY

1. *7 DAYS PRIOR* TO SCHEDULED DELIVERY CONFIRMATION OF SUPPLIES NEEDED
2. *7 DAYS AFTER* DELIVERY RECEIVED SIGN, DATE & RETURN DELIVERY TICKET

ORDER CONFIRMATION 7 DAYS PRIOR TO DELIVERY

YOU MAY CONFIRM IN THE FOLLOWING WAYS
1. CALL 251-338-8051
2. FAX 251-690-4498
3 EMAIL info@portcitymedical.com

Please Provide the Following Information When Confirming

1. PATIENT'S FIRST AND LAST NAME
2. ADDRESS
3. PHONE NUMBER
4. EMAIL ADDRESS (IF APPLICABLE)
5. ITEMS TO BE REFILLED

Orders That Are Not Confirmed Within 7 Days Prior Will* Not *Be Delivered Via Our Delivery Fleet

SIGNED DELIVERY TICKETS

YOU *MUST* COMPLETE, SIGN, DATE RETURN EACH DELIVERY TICKET WITHIN 7 DAYS OF DELIVERY RECEIPT

PLEASE COMPLETE THE REQUIRED FIELDS

- ☐ PATIENT/CAREGIVER/REPRESENTATIVE SIGNATURE
- ☐ PRINTED NAME
- ☐ REASON PATIENT IS UNABLE TO SIGN
- ☐ DATE

YOU MAY RETURN YOUR SIGNED DELIVERYTICKET IN THE FOLLOWING WAYS

1. ***MAIL** TO*: PORT CITY MEDICAL, LLC 8053 AIRWAY PARK DR MOBILE, AL 36608
2. ***FAX** TO*: 251-650-4498
3. **EMAIL** TO: info@portcitymedical.com

PATIENT COPY, PLEASE RETAIN FOR YOUR RECORDS

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PATIENT AUTHORIZATION AND PLAN OF SERVICE

PATIENT NAME_____DOB_____

ADDRESS_____PHONE:_____

CITY_____STATE_____ZIP:_____

EMERGENCY CONTACT_____PHONE

PHYSICIAN_____PHONE NUMBER:_____

DIAGNOSIS_____

PRODUCTS ORDERED_____

PRIMARY INSURANCE_____EFFECTIVE:

PRIMARY POLICY NUMBER_____STATE_____

SECONDARY INSURANCE_____

POLICY NUMBER_____GROUP NUMBER_____

Insurance payment authorization: I request that Medicare, and/or any other insurance provider that I have, to make payments of authorized benefits on my behalf directly to Port City Medical for equipment / supplies they furnish to me and for which they submit claims on my behalf.

Release of insurance information: I request my medical insurance plan(s) to release to the above named company, any and all information which will assist in processing my claims for medical supplies and/or equipment that I am receiving from the above named company even after service to me is discontinued. I also authorized any holder of hospital or medical information about me to release to the health care financing administration, its agents, my insurance company or the above named company any information needed to determine the benefits that are payable for related services.

I understand if my insurance plan(s) makes payment(s) to me for services and supplies that I have received, rather than directly to the above named company, I agree to endorse those checks and send them immediately to the above named company.

I also understand that I am responsible for the payment of any deductible, co-insurance or other portion of my charges not paid by my insurance plan(s). I also understand that I may be eligible for a partial or complete waiver of any unpaid co-insurance charges only, under Port City Medical financial hardship program.

I hereby agree that Port City Medical or any of its affiliates may contact me, or my authorized caregiver, by telephone at my place of residence.

I have reviewed and understand the information above. I have been instructed on and understand the use of the products provided. I have received the products ordered. I have received a copy of a patient handout that contains patient rights and responsibilities, supplier standards, privacy notice and emergency information. I have received the product manual/instructions, warranty information, and instructions to follow up with Port City Medical.

I understand that items prescribed for home care cannot be re-dispensed. Therefore, these items cannot be returned for credit.

I understand that I may lodge a complaint without concern for reprisal, discrimination, or unreasonable interruption of service.

Identified needs/problems: The patient was unfamiliar with use of the product(s) provided. Expected outcomes: The patient will be provided the product(s) to comply with the physician's prescription. The patient will use the product(s) as prescribed by the physician. The patient will know how to obtain follow-up services as needed.

PATIENT OR RESPONSIBLE PARTY SIGNATURE: **X**_____ DATE:_____

IF BENEFICIARY IS UNABLE TO SIGN:
WITNESS SIGNATURE / RELATIONSHIP:_____

REASON PATIENT UNABLE TO SIGN:_____

RETURN THIS COPY- *SIGNED AND DATED*- TO PORT CITY MEDICAL, LLC

8053 Airway Park Dr
Mobile, AL 36608
Phone: (251) 338-8051
Fax: (251) 650-4498
www.portcitymedical.com

INFORMATION RELEASE FORM

PATIENT NAME: (LAST)_____ (FIRST)_____

DATE OF BIRTH:_____

ADDRESS:_____

(CITY)_____ (STATE)_____ (ZIP)_____

I, the undersigned, acknowledge that I have received, read and understand Port City Medical's, LLC Notice of Privacy Practices (HIPAA).

I hereby authorize Port City Medical, LLC to release / obtain prescriptions, letters of medical necessity, growth charts (if applicable) and health insurance information on the above named patient.

To/From:
DR. _____
PRIMARY INSURANCE:_____
SECONDARY INSURANCE:_____
TERTIARY INSURANCE:_____

For: Company operations and third party payment.

X_____
Signature of Patient, Parent or Guardian Relationship to Patient Date

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PATIENT BILL OF RIGHTS AND RESPONSIBILITIES

We believe that all patients receiving services from Port City Medical should be informed of their rights. Therefore, you are entitled to:

1. Be fully informed in advance about care/service to be provided, including the disciplines that furnish care and the frequency of visits, as well as any modifications to the plan of care
2. Be informed, both orally and in writing, in advance of care being provided, of the charges, including payment for care/service expected from third parties and any charges for which the client/patient will be responsible
3. Receive information about the scope of services that the organization will provide and specific limitations on those services
4. Participate in the development and periodic revision of the plan of care
5. Refuse care or treatment after the consequences of refusing care or treatment are fully presented
6. Be informed of client/patient rights under state law to formulate an Advanced Directive, if applicable
7. Have one's property and person treated with respect, consideration, and recognition of client/patient dignity and individuality
8. Be able to identify visiting personnel members through proper identification
9. Be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of client/patient property
10. Voice grievances/complaints regarding treatment or care, lack of respect of property or recommend changes in policy, personnel, or care/service without restraint, interference, coercion, discrimination, or reprisal
11. Have grievances/complaints regarding treatment or care that is (or fails to be) furnished, or lack of respect of property investigated
12. Confidentiality and privacy of all information contained in the client/patient record and of Protected Health Information
13. Be advised on agency's policies and procedures regarding the disclosure of clinical records
14. Choose a health care provider, including choosing an attending physician, if applicable
15. Receive appropriate care without discrimination in accordance with physician orders, if applicable
16. Be informed of any financial benefits when referred to an organization
17. Be fully informed of one's responsibilities

PATIENT RESPONSIBILITIES

1. Patient agrees that rental equipment will be used with reasonable care, not altered or modified, and returned in good condition (normal wear and tear excepted).
2. Patient agrees to promptly report to Port City Medical any malfunctions or defects in rental equipment so that repair/ replacement can be arranged.
3. Patient agrees to provide Port City Medical access to all rental equipment for repair/replacement, maintenance, and/or pick-up of the equipment.

4 Patient agrees to use the equipment for the purposes so indicated and in compliance with the physician's prescription.
5 Patient agrees to keep the equipment in their possession and at the address, to which it was delivered unless otherwise authorized by Port City Medical
6 Patient agrees to notify Port City Medical of any hospitalization, change in customer insurance, address, telephone number, physician, or when the medical need for the rental equipment no longer exists.
7 Patient agrees to request payment of authorized Medicare, Medicaid, or other private insurance benefits are paid directly to Port City Medical for any services furnished by Port City Medical.
8 Patient agrees to accept all financial responsibility for home medical equipment furnished by Port City Medical
9 Patient agrees to pay for the replacement cost of any equipment damaged, destroyed, or lost due to misuse, abuse or neglect.
10 Patient agrees not to modify the rental equipment without the prior consent of Port City Medical
11 Patient agrees that any authorized modification shall belong to the titleholder of the equipment unless equipment is purchased and paid for in full.
12 Patient agrees that title to the rental equipment and all parts shall remain with Port City Medical at all times unless equipment is purchased and paid for in full.
13 Patient agrees that Port City Medical shall not insure or be responsible to the patient for any personal injury or property damage related to any equipment; including that caused by use or improper functioning of the equipment; the act or omission of any other third party, or by any criminal act or activity, war, riot, insurrection, fire or act of God
14 Patient understands that Port City Medical retains the right to refuse delivery of service to any patient at any time.
15 Patient agrees that any legal fees resulting from a disagreement between the parties shall be borne by the unsuccessful party in any legal action taken.

When the patient is unable to make medical or other decisions, the family should be consulted for direction.

All staff members will understand and be able to discuss the Patient Bill of Rights and Responsibilities with the patient and caregiver(s). Each staff member will receive training during orientation and attend an annual in-service education class on the Patient Bill of Rights and Responsibilities.

The patient and caregiver(s) will also receive a copy of the DMEPOS Supplier Standards, which is included in the Patient Handouts forms.

X_____

Signature of Patient, Parent or Guardian **Date**

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PATIENT ACKNOWLEDGEMENT OF DOCUMENTATION RECEIPT

I, the undersigned, acknowledge that I have *received, read and understand* the following documents provided to me from Port City Medical, LLC:

Patient's Rights and Responsibilities *
Patient Agreement *
Patient Information Release *
Patient Acknowledgement of Receipt *
Scope of Services *
DMEPOS Medicare Supplier Standards
Notice of Privacy Practices
Patient Complaint/Grievances Policy
Billing and Reimbursement Practices
Emergency Policies & Procedures for Patients

* ***I have completed the documents (marked with an *) required by Port City Medical, LLC in order to initiate the services I've requested. ALL five (4) documents requiring a signature will be returned in the self-addressed, stamped envelope provided to me by Port City Medical, LLC.***

Patient Name (Last)_____ (First)_____

X_____
Patient or Patient Guardian/Caregiver Signature **DATE**

RETURN TO PORT CITY MEDICAL, LLC