CHARM
MEDICAL SUPPLY

Dear New Patient,

Welcome and thank you for choosing Charm Medical Supply for your home healthcare needs! Enclosed in this packet you will find the following documents:

*** THESE DOCUMENTS *MUST* BE COMPLETED, SIGNED AND *RETURNED* TO CHARM MEDICAL SUPPLY:**

Patient's Rights and Responsibilities *

Patient Agreement *

Delivery Authorization *

Patient Information Release *

Patient Acknowledgement of Receipt *

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

Community Resource List

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 Charm *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.charmmedical.com to see our full product offerings.

Thank you for choosing Charm Medical Supply. We look forward to working with you!

Sincerely,
Charm Medical Supply

33 Riverside Dr. Suite 200, Pembroke, MA 02359
781-829-9813 (local), 877-94-CHARM (toll free), 781-829-9836 (fax)
www.charmmedical.com

CHARM MEDICAL SUPPLY

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

CHARM MEDICAL SUPPLY

PATIENT'S RIGHTS AND RESPONSIBILITIES

As a patient you have the *right* to:

1. Choose your provider of home medical supplies and equipment. You also have the right to refuse service within the confines of the law and be given information concerning consequence of refusing services.
2. Receive a timely response from Charm Medical Supply regarding your request for home medical supplies and equipment.
3. Be given appropriate service without discrimination due to diagnosis, race, creed, color, religion, sex, national origin, sexual preference, handicap, disability or age.
4. Be treated with courtesy and respect by all Charm Medical Supply personnel who provide service to you, in addition to being free from physical and mental abuse, neglect and exploitative practices.
5. Be given proper identification by name and title of all Charm Medical Supply personnel who provide service to you.
6. Be given all necessary information, in a manner you can understand, so that you will be able to give informed consent for your services.
7. Receive complete privacy and confidentiality with regard to your condition, diagnosis, records, files, and any other personal health information or pertinent data as mandated by federal HIPAA regulations.
8. Access and review your records as mandated by federal HIPAA regulations.
9. Be involved in the planning and ordering process in addition to being notified of any changes in your medical equipment and/or supply services.
10. Register any complaints regarding services with us and/or appropriate federal and state agencies without fear of discrimination or unreasonable interruption of services. Patients may call our office with any complaints, grievances, and/or recommendations for change. Patients may also call MassHealth at 1-800-841-2900 or Medicare at 1-800-633-4227. (*Please see the* Patient Complaints/Grievances Policy *included with the information packet for further information on our complaint policy and procedure.)*
11. Rent or purchase inexpensive/routinely purchased Medicare items.
12. Patients also have the right to refuse any service.

As a patient you have the *responsibility* to:

1. ***Promptly complete, date, sign and return each delivery ticket*** per delivery received to Charm Medical Supply.
2. ***Confirm*** supplies needed ***each*** and ***every*** month, as required by your insurance payor.
3. ***Inform*** Charm Medical Supply of ***any*** changes in your health insurance or other third party payer coverage.
4. ***Inform*** Charm Medical Supply of ***any*** changes in your address or telephone number.
5. ***Inform*** Charm Medical Supply if you are under the care plan of another Home Medical Equipment provider.
6. ***Provide accurate and complete health information*** and report any unexpected changes in your condition to your physician, as this may require a change in your home medical equipment and supplies.
7. ***Meet financial commitments*** by promptly meeting any financial obligation agreed to with Charm Medical Supply. Patient is financially responsible for invoices not covered due to ineligibility on date of service. Patient has the option to return the unused/unopened product. *(Please see the* Billing and Reimbursement Practices *and* Patient Responsibility *documents included with the information packet for more information).*
8. ***Follow instructions*** on the care, use and maintenance of equipment and return rental equipment in good condition.
9. ***Show respect*** and consideration for Charm Medical Supply personnel and property.
10. ***Provide feedback*** to Charm Medical Supply regarding service needs and expectations.
11. ***Read, complete & sign the Notice of Privacy Practices*** included with this information packet.
12. ***Request*** further information concerning anything you do not understand.

PATIENT COPY

Please retain for your records

PATIENT COMPLAINTS/GRIEVANCES POLICY

Patients/clients and caregivers have the right to have all complaints heard, investigated and whenever possible, resolved. TMed Holdings Inc., dba Charm Medical Supply 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.

TMed receives, investigates and responds to complaints and recommendations received from patients/clients. Upon admission, TMed provides oral and/or written notification of its complaint-resolution process and other resources for registering complaints. The patient's/customer's record must document all communication, signed and dated by a staff member.

A patient/client may file a complaint or grievance by calling customer service at 877-94-CHARM or 781-829-9813. The complaint may also be submitted in writing to the Company President, Peter Tallas at the TMed Pembroke office.

The complainant will be notified within 5 business days of receipt that the complaint has been received and is being investigated. The Company will initiate an investigation by interviewing staff involved, reviewing delivery van logs, checking patient's file including delivery slips and other documentations. If necessary, the patient and/or caregiver will be contacted for more information. If collateral sources are to be contacted for information, the patient will be notified and information release forms will be obtained.

Within 14 business days, a written response of the outcome of such investigation for the complaint resolution will be sent to the patient.

A complete report of the initial complaint and subsequent investigation and resolution is to be kept by the Compliance Manager in a secure file, and a summary is documented in the patient's file.

Patients may call our accrediting organization, CHAP, to file a complaint or question about Charm Medical Supply as an organization if deemed necessary.
CHAP Hotline: 1-800-656-9656 (9-5pm Monday-Friday).

Patients may also call MassHealth at 1-800-841-2900 or Medicare at 1-800-633-4227 to register complaint, if deemed necessary.

NOTICE OF PRIVACY PRACTICES

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

EFFECTIVE SEPTEMBER 18, 2013
THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR PROTECTED HEALTH INFORMATION.
PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

The terms of this notice apply to all records containing your protected health information that are created, received, maintained or transmitted by our Company, our Business Associates and their subcontractors. We reserve the right to revise and amend our notice of privacy practices. Any revision or amendment to this notice will be effective for all of your records our company has created or maintained in the past, and for any of your records we may create, receive, maintain or transmit in the future. Our Company will post a copy of our most current notice in our offices in a prominent location and on our website. You may request a copy of our most current notice by telephone, in writing or by e-mail.

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

Peter Tallas - President, (781) 829-9813, 33 Riverside Drive Suite 200, Pembroke, MA 02359.

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

The following categories describe different ways in which we may use and disclose your identifiable health information. Except for the purposes described below, any other uses or disclosures of protected health information not covered by this notice to include for the purposes of marketing or disclosures that would constitute a sale of your protected health information and or the laws that govern us will only be made with your written authorization.

1. Treatment. Our company may use and disclose your protected health information for your treatment and to provide you with treatment related services. For example, we may disclose health information to doctors, nurses, or other personnel, including people outside our office / company, who are involved in your medical care and need the information to provide you with medical care.

2. Payment. Our company may use and disclose your protected health information in order to bill and collect payment for the services and items you receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits and we may provide your insurer with details regarding your services and home healthcare items to determine if your insurer will cover, or pay for, these services and items. We also may use and disclose your protected health information to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your protected health information to bill you directly for services and items not covered by health insurance.

3. Health Care Operations. Our company may use and disclose your protected health information to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our company 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 company.

4. Business Associates. Business Associates are parties with which we conduct business in order to provide you with our services which include but are not limited to provisions of medical equipment and its assembly, medical supplies, home delivery service of equipment and supplies, and medical billing to your health insurance payer, yourself or other designated parties. Our company may use and disclose your protected health information to Business Associates. Business Associates will be provided only with the minimum of health information necessary in order for them to perform the activities of their business that they conduct on our behalf.

5. Appointment Reminders. Our company may use and disclose your protected health information to contact and remind you of visits/deliveries.

6. Health-Related Benefits and Services. Our company may use and disclose your protected health information to inform you of health-related benefits or services that may be of interest to you.

7. Release of Information to Family/Friends. Our company may release your protected health information to your family, a relative, a close friend or any other person you identify as involved in helping you pay for your health care, or who assists in taking care of you, unless you object. Please see "YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION" section of this Notice of Privacy Practices for further information.

8. Disclosures required by law. Our company will use and disclose your protected health information when we are required to do so by federal, state or local law.

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

The following categories describe unique scenarios in which we or our Business Associates (only if or when applicable) may use or disclose your protected health information:

1. Public Health Risks. Our company may disclose your protected health information to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records such as births and death
- Reporting child abuse or neglect
- Preventing or controlling disease, injury or disability
- Notifying a person regarding potential risk for spreading or contracting a disease or condition
- Reporting 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); we will only disclose this information if the patient agrees or we are required or authorized by law to disclose information.

2. Health Oversight Activities. Our organization may disclose your protected health information to a health agency for activities authorized by law. Oversight activities can include for example, investigations, 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 systems in general.

3. Lawsuits and Similar Proceedings. Our organization may use and disclose your protected 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 protected 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 or to obtain an order protecting the information the party has requested.

4. Law Enforcement. We may release protected 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 contact
- Regarding criminal contact 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(s) or victim(s) of the crime, or the description(s), identity(ies) or location(s) of the perpetrator(s).

5. Serious Threats to Health or Safety. Our organization may use and disclose your protected 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 prevent the threat.

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

8. Workers' Compensation. Our organization may release your protected health information for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

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

1. Inspection and Copies. You have the right to inspect and obtain a copy of protected 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 to: **Peter Tallas – President, (781) 829-9813, 33 Riverside Drive Suite 200, Pembroke, MA 02359**, in order to inspect and/or obtain a copy of your protected health information. Our organization may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our company 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.

2. Electronic Copy of Electronic Medical Records. If your protected health information is maintained in an electronic format (that is, a digital electronic medical or health record), you have the right to request that an electronic copy of your record be sent or transmitted to you or to another individual or entity. Presently our organization doesn't utilize an electronic medical or health record format. However, if we at some point implement use of an electronic medical / health record format you will be eligible to request your heath records in this format.

3. Right to Request Protected Health Information be Sent to Directly to Another Individual / Third Party. If you wish to have your protected health information sent to a third party your request must be made in writing and submitted to: **Peter Tallas – President, (781-829-9813, 33 Riverside Drive, Suite 200 Pembroke, MA 02359**. Your request must clarify the identity of the persons designated to receive this information and the address to which copies must be sent.

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 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: **Peter Tallas – President, (781) 829-9813, 33 Riverside Drive Suite 200, Pembroke, MA 02359**. You must provide us with reasons that support 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. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your identifiable health information for payment or health care operations. Additionally, you have the right to request that we limit our disclosure of your protected health information to individuals involved in your care or payment for your care, such as family members and friends. **We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your protected health information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out of pocket" in full.** If we do agree we will comply with your request unless the information is required by law, or is needed to provide you with emergency treatment. In order to request a restriction in our use or disclosure of your protected health information, you must make your request in writing to: **Peter Tallas – President, (781) 829-9813, 33 Riverside Drive Suite 200, Pembroke, MA 02359**. Your request must describe in a clear and concise fashion: (a) information you wish restricted; (b) whether you are requesting to limit our company's use, disclosure or both; and (c) to whom you want limits to apply.

6. Breach. You have the right to be notified upon a breach of any of your unsecured protected health information.

7. Accounting of Disclosure. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain disclosures our organization has made of your protected health information. In order to obtain an accounting of disclosures, you must submit your request in writing to, **Peter Tallas – President, (781) 829-9813, 33 Riverside Drive Suite 200, Pembroke, MA 02359**. All requests for an "accounting of disclosures" must state a time period which may not be longer than six years from the date of your request. The first list you request within a 12-month period is free of charge, but our company 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.

8. Fundraising. Entities that may use or disclose your protected health information for the purpose of fundraising activities are required to inform you of such and offer you the opportunity to opt out of participation in any fundraising activities in which your protected health information may be used or disclosed. Our organization does not engage in any fundraising activities that would involve the use or disclosure of your protected health information.

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

10. 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: **Peter Tallas – President, (781) 829-9813, 33 Riverside Drive Suite 200, Pembroke, MA 02359**, 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.

11. 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, contact **Peter Tallas – President, (781) 829-9813, 33 Riverside Drive Suite 200, Pembroke, MA 02359**. All complaints must be submitted in writing. **You will not be penalized for filling a complaint**.

12. 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 **Peter Tallas – President, (781) 829-9813, 33 Riverside Drive Suite 200, Pembroke, MA 02359**.

CHARM MEDICAL SUPPLY

BILLING AND REIMBURSEMENT PRACTICES

Our mission at Charm Medical Supply is to offer our clients outstanding service and simplify the way that medical supplies are ordered and received. Charm Medical Supply manages all of the requirements associated with ordering supplies under Medicare, MassHealth, 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 Charm Medical Supply 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

Masshealth	Medicare	United
NHP	Blue Cross Blue Shield	Unicare
Network Health	Harvard Pilgrim	*AND MORE**
Commonwealth Care	Tufts HMO	
Alliance	Fallon	

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

For questions about your billing or insurance coverage, please call Customer Service at
(877) 94-CHARM

EMERGENCY POLICIES & PROCEDURES *FOR PATIENTS*

The goal at Charm Medical Supply is to provide services to our clients as promptly and efficiently as possible. However, safety *must* be a priority in consideration of our clients and staff alike.

In the case of an emergent event that could cause interruption of services, such as natural disaster or inclement weather, Management and Customer Service will attempt to work with clients scheduled to receive a delivery within the specific timeframe of the event to coordinate alternate arrangements, such as early delivery or customer pickup, to ensure supplies can be received in a safe and timely manner.

If such an event should occur, deliveries will have to be prioritized to ensure the health and safety of high priority clients will not be compromised (i.e. feeding pump patients). This prioritization is as follows:

PRIORITIZATION OF DELIVERY:

1. **FEEDING PUMP PATIENTS**
2. **FORMULA PATIENTS**
3. **DURABLE MEDICAL SUPPLIES/EQUIPMENT**
4. **INCONTINENCE SUPPLY PATIENTS**

INCLEMENT WEATHER:

In the case of inclement weather (i.e., severe snowstorm, thunderstorm, hurricane, etc.), deliveries will be pushed up in attempt to deliver to as many clients as possible before the storm is in full effect. Clients whose routes will be delivered ahead of time will receive an automated voice message informing them that the early delivery will take place due to the inclement weather. *It is then the responsibility of the client and/or client's caregiver to call Customer Service to make an alternate arrangement* if *they will not be able to accept this early delivery.*

If Charm Medical Supply is unable to deliver products to clients safely, and/or no alternate arrangements are made, it is agreed that the clients' deliveries will be made *as soon as safety conditions are restored* and/or deemed possible by Management.

EVACUATION DUE TO AN EMERGENT EVENT

A wide variety of emergencies, both man-made and natural, may require CHARM MEDICAL SUPPLY to be evacuated. These emergencies include - fires, explosions, floods, earthquakes, hurricanes, tornadoes, toxic material releases, radiological and biological accidents, civil disturbances and workplace violence. In the case in which any of the above mentioned events occur and Charm Medical Supply is to be evacuated, The Company will send an automated message to the effected clients *remotely*. Clients will receive the automated notification - *within 12 hours after the event*- informing the client that an emergent event has occurred and services may not be able to be provided unless alternate arrangements are made. **It is then the responsibility of the client or client's caregiver to call the number provided in the message to pursue the attempt to make such an arrangement.**

If the client and Charm Medical Supply are unable to successfully make an alternate arrangement for their delivery, it is agreed that the client's delivery will be made as soon as safety conditions are restored and/or deemed possible by Management.

The ability for Charm Medical Supply to assist in these situations will take into account environmental conditions, safety concerns and any restrictions placed on travel by federal, state or local authorities.

FEEDING PUMP EMERGENCIES

TMed Holdings Inc – Charm Medical Supply has personnel available 24 hours a day, 7 days a week for emergencies involving enteral feeding pump malfunction. For emergencies occurring after business hours, calls are directed to a live answering service that has procedures for contacting TMed personnel. When a call is received from a patient/caregiver, a service/repair technician or other trained staff will determine the problem. If the problem cannot be solved over the phone with patient/caregiver, then another pump will be delivered as soon as possible, with consideration of the time of day and patient convenience, but no later than the following day if the call is received at night. If patient/caregiver prefers, they may call the pump manufacturer direct at a toll free number provided to all pump patients. This is a 24-hour/7day-tech support line.

IN THE EVENT OF INCLEMENT WEATHER deliveries are prioritized, and emergency deliveries will be made via a vehicle equipped with 4-wheel drive. Additional resources would be Pembroke Fire or Police for assistance, if needed.

IN THE EVENT OF A NATURAL OR MAN-MADE DISASTER where the power failure is expected to last for more than a day or two, TMed Holdings, Inc will assist the patient/client to the extent possible. Enteral feeding pumps are battery powered. Information about the battery operation time and charging the battery is contained in the Operator's Manual provided with each pump. Assistance may consist of exchanging the pump for a fully charged one or removing the pump, recharging it and returning it to the patient/client.

CHARM MEDICAL SUPPLY

COMMUNITY RESOURCE LIST

FIRE **PEMBROKE FIRE DEPT.**	**781-293-2300**
POLICE **PEMBROKE POLICE DEPT.**	**781-293-6363**
HOSPITAL	**PEMBROKE: 781- 829-7000** **SOUTH SHORE: 781-624-8000**
AMBULANCE	**ROCKLAND: (781) 878-2123** **FALLON: (617) 482-8181**
COUNCIL OF AGING	**Pembroke: 781-294-8220** **Plymouth: 508 747-0401**
NATIONAL DOMESTIC VIOLENCE HOTLINE http://www.ndvh.org/	**1-800-799-SAFE** **(7233)**
BATTERED WOMEN'S HOTLINE www.transitionhouse.org	**Boston, MA (877) 785-2020** **Waltham, MA (800) 899-4000**
ELDER ABUSE HOTLINE	**1-800-922-2275**
CHILD ABUSE HOTLINE **(24 hours a day)**	**1-800-4-A-CHILD** **(1-800-422-4453)**
DISABLED PERSONS PROTECTION COMMISSION www.mass.gov/dppc	**1-800-426-9009**
ANIMAL ABUSE HOTLINE **www.mspca.org**	**1-800-628-5808**
HOSPICE OF SOUTH SHORE www.southshorehospital.org	**781-794-7877** **781-843-0947 (referrals)**
VISITING NURSE ASSOCIATION www.vnaa.org	**Norwell VNA** **781-659-2342** **Overlook VNA New Bedford** **508- 998-7348**
MEALS ON WHEELS mowaa@mowaa.org	**Old Colony Elderly Services, Inc.** **Brockton (508) 584-1561**
NUTRITION PROGRAM LOCATOR www.eldercare.gov	**(800) 677-1116**
OXYGEN: **CLINICAL 1 HOME MEDICAL** mm@clinical1homemedical.com	**Phone: (781) 331-6856** **Toll Free: (800) 261-5737**
INFUSION & OXYGEN **Boston Home Infusion, Inc** www.bostonhomeinfusion.com	**(781) 326-1986**
CPM MACHINES/ BRACES **SURGI-CARE** www.surgi-careinc.com	**Waltham, Ma** **800-797-8744**

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

- ***MONTHLY AUTOMATED CALL (CALL FIRE):***
  - LIVE: When you receive the monthly automated call live, you will be instructed to;

    PRESS 1. TO CONFIRM
    2. TO DECLINE
    3. TO BE CONNECTED TO OUR CUSTOMER SERVICE STAFF
  - VOICEMAIL MESSAGE: When you receive the monthly Call Fire message, you will be instructed to: CALL US BACK AT: 781 829 9813, EXTENSION 04.

- ***ONLINE***: YOU MAY ALSO CONFIRM AT YOUR CONVENIENCE VIA OUR WEBSITE: www.charmmedical.com

Please Provide The Following Information When Confirming:

- PATIENT'S FIRST & LAST NAME
- ADDRESS
- PHONE NUMBER
- EMAIL ADDRESS, IF APPLICABLE
- ITEMS TO BE REFILLED
- ADDITIONAL REQUESTS OR INFORMATION

(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 DELIVERY TICKET IN THE FOLLOWING WAYS:

- TO **DRIVER** AT TIME OF DELIVERY
- ***MAIL*** *TO*: 33 RIVERSIDE DRIVE, SUITE 200, PEMBROKE MA 02359
- ***FAX*** *TO*: 781 829 9836
- **EMAIL** TO: CUSTOMERSUPPORT@CHARMMEDICAL.COM

CHARM
MEDICAL SUPPLY

INFORMATION RELEASE FORM

PATIENT NAME: «PDPatient_First_Nme» «PDPatient_Last_Name»

DATE OF BIRTH: «PDPatient_Birthdate»

ADDRESS: «PDPatient_Street»«PDAddress_Line_2» «PDPatient_City» «PDPatient_State» 0«PDPatient_ZIP_Code»

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

I hereby authorize Charm Medical Supply to release / obtain prescriptions, letters of medical necessity, growth charts (if applicable) and health insurance information on the above named patient.
To/From:

DR. «DRDoctor_Name»

PRIMARY INSURANCE: «PICar_Code» «PICar_Policy_»

SECONDARY INSURANCE: «PICar_Code1» «PICar_Policy_1»

TERTIARY INSURANCE: «PICar_Code2» «PICar_Policy_2»

For: Company operations and third party payment.

X_____

Signature of Patient, Parent or Guardian Relationship to Patient Date

RETURN THIS COPY- *SIGNED AND DATED*- TO CHARM MEDICAL SUPPLY

CHARM
MEDICAL SUPPLY

PATIENT AGREEMENT

Social Security #	Health Insurance I.D. # «PICar_Code» «PICar_Policy_» «PICar_Code1» «PICar_Policy_1» «PICar_Code2» «PICar_Policy_2»
Patient Name **«PDPatient_First_Nme» «PDPatient_Last_Name»**	
Address **«PDPatient_Street» «PDPatient_City», MA 0«PDPatient_ZIP_Code»**	Telephone # **«PDPat_Phone»**
Type of Healthcare Product and or Service **Misc.Supplies**	Effective Date **October 1, 2013**

REQUEST FOR PROVISION OF SERVICES

I understand that by signing this agreement, I indicate my wish to purchase health care products or service or both from Charm Medical Supply, a division of **TMed Holdings, Inc.**

INDICATION OF MEDICAL RESPONSIBILITY

I understand that I am signing under the supervision and control of my attending physician. I understand that Charm Medical Supply's services do not include diagnostic, prescriptive or other functions typically performed by licensed physicians, and that my physician is solely responsible for diagnosing and prescribing drugs, supplies, equipment and services for my condition and otherwise supervising and controlling my medical care.

RELEASE OF INFORMATION

I authorize my insurer(s), and any other third party payor who provides me with coverage, to disclose to Charm Medical Supply any information regarding such coverage, including, but not limited to, payments made by such insurer(s) or third party payor(s) to me, for home healthcare products or services rendered to me by Charm Medical Supply, and the scope and extent of coverage available from time to time. I authorize all medical personnel to provide information to Charm Medical Supply concerning my medical history as it may relate to my home services and health care product needs. If my primary insurance changes, I agree to notify Charm Medical Supply.

CREDIT CHECK AUTHORIZATION AND CREDIT TERMS

Charm Medical Supply is authorized to verify any information I have disclosed and perform a credit investigation for the purpose of extending credit for the purchase or rental of medical equipment. In addition, Charm Medical Supply may answer questions from other creditors about my credit and account experience with Charm Medical Supply.

ASSIGNMENT OF BENEFITS

I authorize Charm Medical Supply to request on my behalf, and to collect directly, all public and private insurance coverage benefits due for products and services supplied by Charm Medical Supply. In the event payments for insurance benefits are made directly to me, the payee, I will endorse all checks for payment to Charm Medical Supply. I accept all responsibility for overpayments per statement.

EXTENDED MEDICARE ASSIGNMENT

I certify that the information given by me for payment under Medicare (Title XVIII of the Social Security Act) and/or other medical insurance is correct.

1. The patient, if physically and mentally competent, must sign on his/her behalf. If he/she cannot sign for himself/herself, a representative payee as designated by the Social Security Administration, or a legally appointed guardian, may sign. The source of the signatoree's authority should be stated (e.g. "Social Security appointed Representative Payee," or "court appointed guardian," etc.).

2. This form is used in lieu of the patient's signature on the "Request for Payment" HCFA-1500 (I-84) and is therefore an extension of that form. Anyone who misrepresents or falsifies essential information in making Medicare claims may, upon conviction, be subjected to fine and imprisonment under Federal law. Furthermore, in signing, the beneficiary authorizes any holder of medical or other information about himself/herself to release to the Social Security Administration or its intermediaries or carrier any information needed to process related Medicare claims. He/she further permits a copy of the authorization to be used in place of original.

3. On assigned claims, the provider agrees to accept the Medicare carriers' allowable amount as the full charge for covered services; the patient is responsible for the deductible, co-insurance and non-covered services. This authorization may be cancelled by mutual agreement of the provider and customer at any time by written notice to the Medicare Center.

I request payment under the Medical Insurance Part of MEDICARE be made directly to Charm Medical Supply for service furnished me during the effective period of this authorization. I have read and I agree to the release of information as specified in Paragraph 2 above.

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

NOTE: A copy of this Agreement and Consent shall be considered the same as an original.

Manager: ***PETER TALLAS*** **Telephone: 877-94-CHARM**

X _____

Patient/Spouse/Guarantor/Guardian Signature **Relationship to Patient** **Date**

RETURN THIS COPY- *SIGNED AND DATED*- TO CHARM MEDICAL SUPPLY

33 Riverside Dr Suite 200, Pembroke, MA 02359
781-829-9813 (local), 877-94-CHARM (toll free), 781-829-9836 (fax)
www.charmmedical.com

CHARM
MEDICAL SUPPLY

PATIENT AGREEMENT

Social Security #	Health Insurance I.D. # «PICar_Code» «PICar_Policy_» «PICar_Code1» «PICar_Policy_1» «PICar_Code2» «PICar_Policy_2»
Patient Name **«PDPatient_First_Nme» «PDPatient_Last_Name»**	
Address **«PDPatient_Street» «PDPatient_City», MA 0«PDPatient_ZIP_Code»**	Telephone # **«PDPat_Phone»**
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CREDIT CHECK AUTHORIZATION AND CREDIT TERMS

Charm Medical Supply is authorized to verify any information I have disclosed and perform a credit investigation for the purpose of extending credit for the purchase or rental of medical equipment. In addition, Charm Medical Supply may answer questions from other creditors about my credit and account experience with Charm Medical Supply.

ASSIGNMENT OF BENEFITS

I authorize Charm Medical Supply to request on my behalf, and to collect directly, all public and private insurance coverage benefits due for products and services supplied by Charm Medical Supply. In the event payments for insurance benefits are made directly to me, the payee, I will endorse all checks for payment to Charm Medical Supply. I accept all responsibility for overpayments per statement.

EXTENDED MEDICARE ASSIGNMENT

I certify that the information given by me for payment under Medicare (Title XVIII of the Social Security Act) and/or other medical insurance is correct.

4. The patient, if physically and mentally competent, must sign on his/her behalf. If he/she cannot sign for himself/herself, a representative payee as designated by the Social Security Administration, or a legally appointed guardian, may sign. The source of the signatoree's authority should be stated (e.g. "Social Security appointed Representative Payee," or "court appointed guardian," etc.).

5. This form is used in lieu of the patient's signature on the "Request for Payment" HCFA-1500 (I-84) and is therefore an extension of that form. Anyone who misrepresents or falsifies essential information in making Medicare claims may, upon conviction, be subjected to fine and imprisonment under Federal law. Furthermore, in signing, the beneficiary authorizes any holder of medical or other information about himself/herself to release to the Social Security Administration or its intermediaries or carrier any information needed to process related Medicare claims. He/she further permits a copy of the authorization to be used in place of original.

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

NOTE: A copy of this Agreement and Consent shall be considered the same as an original.

Manager: ***PETER TALLAS*** **Telephone: 877-94-CHARM**

PATIENT COPY, PLEASE RETAIN FOR YOUR RECORDS

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www.charmmedical.com

CHARM MEDICAL SUPPLY

PATIENT'S RIGHTS AND RESPONSIBILITIES

As a patient you have the *right* to:

1. Choose your provider of home medical supplies and equipment. You also have the right to refuse service within the confines of the law and be given information concerning consequence of refusing services.
2. Receive a timely response from Charm Medical Supply regarding your request for home medical supplies and equipment.
3. Be given appropriate service without discrimination due to diagnosis, race, creed, color, religion, sex, national origin, sexual preference, handicap, disability or age.
4. Be treated with courtesy and respect by all Charm Medical Supply personnel who provide service to you, in addition to being free from physical and mental abuse, neglect and exploitative practices.
5. Be given proper identification by name and title of all Charm Medical Supply personnel who provide service to you.
6. Be given all necessary information, in a manner you can understand, so that you will be able to give informed consent for your services.
7. Receive complete privacy and confidentiality with regard to your condition, diagnosis, records, files, and any other personal health information or pertinent data as mandated by federal HIPAA regulations.
8. Access and review your records as mandated by federal HIPAA regulations.
9. Be involved in the planning and ordering process in addition to being notified of any changes in your medical equipment and/or supply services.
10. Register any complaints regarding services with us and/or appropriate federal and state agencies without fear of discrimination or unreasonable interruption of services. Patients may call our office with any complaints, grievances, and/or recommendations for change. Patients may also call MassHealth at 1-800-841-2900 or Medicare at 1-800-633-4227. (*Please see the* Patient Complaints/Grievances Policy *included with the information packet for further information on our complaint policy and procedure.)*
11. Rent or purchase inexpensive/routinely purchased Medicare items.
12. Patients also have the right to refuse any service.

As a patient you have the *responsibility* to:

1. ***Promptly complete, date, sign and return each delivery ticket*** per delivery received to Charm Medical Supply.
2. ***Confirm*** supplies needed ***each*** and ***every*** month, as required by your insurance payor.
3. ***Inform*** Charm Medical Supply of ***any*** changes in your health insurance or other third party payer coverage.
4. ***Inform*** Charm Medical Supply of ***any*** changes in your address or telephone number.
5. ***Inform*** Charm Medical Supply if you are under the care plan of another Home Medical Equipment provider.
6. ***Provide accurate and complete health information*** and report any unexpected changes in your condition to your physician, as this may require a change in your home medical equipment and supplies.
7. ***Meet financial commitments*** by promptly meeting any financial obligation agreed to with Charm Medical Supply. Patient is financially responsible for invoices not covered due to ineligibility on date of service. Patient has the option to return the unused/unopened product. *(Please see the* Billing and Reimbursement Practices *and* Patient Responsibility *documents included with the information packet for more information).*
8. ***Follow instructions*** on the care, use and maintenance of equipment and return rental equipment in good condition.
9. ***Show respect*** and consideration for Charm Medical Supply personnel and property.
10. ***Provide feedback*** to Charm Medical Supply regarding service needs and expectations.
11. ***Read, complete & sign the Notice of Privacy Practices*** included with this information packet.
12. ***Request*** further information concerning anything you do not understand.

«PDPatient_First_Nme» «PDPatient_Last_Name»

X_____

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

RETURN THIS COPY- *SIGNED AND DATED*- TO CHARM MEDICAL SUPPLY

33 Riverside Dr. Suite 200, Pembroke, MA 02359
781-829-9813 (local), 877-94-CHARM (toll free), 781-829-9836 (fax)
www.charmmedical.com

CHARM MEDICAL SUPPLY

TOLL FREE: 877-94-CHARM

PATIENT ACKNOWLEDGEMENT OF DOCUMENTATION RECEIPT

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

PHYSICIAN INFORMATION

Patient's Rights and Responsibilities *

Patient Agreement *

Delivery Authorization *

Patient Information Release *

Patient Acknowledgement of Receipt *

DMEPOS Medicare Supplier Standards

Notice of Privacy Practices

Patient Complaint/Grievances Policy

Billing and Reimbursement Practices

Emergency Policies & Procedures for Patients

Community Resource List

Diagnoses:

* ***I have completed the documents (marked with an *) required by Charm Medical Supply in order to initiate the services I've requested. ALL five (5) documents requiring a signature will be returned in the self-addressed, stamped envelope provided to me by Charm Medical Supply.***

«PDPatient_First_Nme» «PDPatient_Last_Name»
Patient Name

X _____

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

RETURN THIS COPY- *SIGNED AND DATED*- TO CHARM MEDICAL SUPPLY

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www.charmmedical.com

CHARM MEDICAL SUPPLY

DME REFERRAL FORM

TOLL FREE: 877-94-CHARM

DME 781-829-9813X-135
DME FAX: 781-561-7225

REFERRAL BEING REQUESTED BY:

Name:
Relationship:
Phone #:
How did you hear about CHARM?

HAS THE BENEFICIARY BEEN NOTIFIED THAT SUPPLIES ARE BEING REQUESTED ON THEIR BEHALF AND TO EXPECT A CALL FROM CHARM?

Primary MD:
Practice Name:
Street:
City:
Phone:
Fax:

For Group Homes, Assisted Living, etc: HOUSE MANAGER CONTACT INFORMATION

Name:
Title:
Phone #:
Is there a VNA in the home?
Name:
Phone #:

PATIENT INFORMATION: Please complete all lines

Organization Name:
Patient Name:
Street:
Apt/Floor:
City:
Zip Code:
DOB:
Phone (Main):
Phone (ALT):
FAX:
E-Mail:
Weight:
Height:
Diagnoses:
Primary Language:
Does any person in the residence have a Communicable disease?
If yes:

EQUIPMENT REQUESTED:

SAME / SIMILAR

MEDICARE :

INSURANCE INFORMATION

Primary:
Secondary:
Social Security #:

MEDICAID:
REFERENCE #:
SPOKE WITH?

Date:
Completed by?
Sales:

33 Riverside Dr. Suite 200, Pembroke, MA 02359
781-829-9813 (local), 877-94-CHARM (toll free), 781-559-0795 (fax)