15675 Hawthorne Blvd, Suite D Lawndale, CA 90260 Office: 310-845-6315 Fax: 310-861-8754 info@VMRmedical.com

PATIENT SERVICE AGREEMENT

Patient Name: _____ DOB: _____

Authorization/Consent for Care/Service: I authorize VMR Medical under the direction of the prescribing physician, to provide durable medical equipment, supplies and services as prescribed by my physician.

Assignment of Benefits/Authorization for Payment: I hereby assign benefits and payments to be made directly VMR Medical, for any durable medical equipment, supplies services furnished to me . I authorize VMR Medical to seek such benefits and payments on my behalf. It is understood that, as a courtesy. VMR Medical will bill Medicare/Medicaid or other federally funded sources and other payers and insurer(s) providing coverage, with a copy to VMR Medical I understand that I am responsible for providing all necessary information and for making sure all certification and enrollment requirements are fulfilled. Any changes in the policy must be reported to VMR Medical within 30 days of the event. I have been informed by VMR Medical of the medical necessity for the services prescribed by my physician.

Financial Responsibility: I understand and agree that I am responsible for the payment of any and all sums that may become due for the services provided. These sums include, but are not limited to, all deductibles, co-payments,.

_____ (Initials) I acknowledge that I have been advised of my financial obligations to VMR Medical.

Returned Goods: I understand that, due to Federal and State Regulations ancillary items prescribed for home health care cannot be re-dispensed. Therefore, ancillary items cannot be returned for credit. Sale items cannot be returned. VMR Medical must be notified within 24 hours of the set-up if any equipment is defective. In the case of defective equipment, an exchange will be made for the defective item.

Patient Handouts: I acknowledge that I will receive a copy in the brace mailed package of the Patient Handouts which contains Patient Rights and Responsibilities, Supplier Standards, HIPAA Privacy Standards, I acknowledge that I have received company marketing material and information on the company's scope of services. I acknowledge that the information in the Patient Handouts has been explained to me and that I understand the information.

Complaint Reporting: I acknowledge that I have been informed of the procedure to report a grievance should I become dissatisfied with any portion of my home care experience with my brace(s). I understand that I may lodge a complaint without concern for reprisal, discrimination, or unreasonable interruption of service. To place a grievance, please call (310) 845-6315 and speak to customer services. 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 of receipt.

You may also make inquiries or complaints about this company by calling Medicare at 1-800-MEDICARE, the Accreditation Commission for Health Care (ACHC) at 919-785-1214 and/or the California Dept of Public Health at https://www.cdph.ca.gov

Patient: _____ Date: _____

Witness: _____ Date: _____

Form Revised: 01-30-2020