DMEPOS SETUP and PROOF OF DELIVERY

Patient Name:	Date of Birth:	☐ Purchase ☐ Rental

☐ New Order ☐ Refill Order	☐ Picked Up at Facility Counter	☐ Delivered Patient Residence ☐ Delivered Residential Care Setting ☐ Shipped to Patient Delivery/Shipping Address:

Shipping Company	Shipping Tracking/Invoice Number	Date Shipped

Quantity	Description (Model and Manufacturer)/(Lot, Serial Number and Expirations)	Patient Cost

Patient has:		Documents Given to the Patient:	
Been assessed for the appropriateness of the DMEPOS.	☐	Manufacturer Documentation	☐
Been trained on setup, use, maintenance, storage, and infection Control	☐	Warranty	☐
Been alerted to the potential risks and hazards of the DMEPOS	☐	Patient Satisfaction Survey	☐
Been instructed to report any equipment failure to the Facility	☐	Rental Agreement	☐
Been made aware of the physician's instructions	☐	Capped Rental Form (Medicare Pt Only)	☐
Been Instructed to contact the Physician for changes in condition	☐	Written Instructions	☐
Patient has demonstrated proper use and care of the DMEPOS	☐	Advanced Beneficiary Notice (Medicare Pt Only)	☐
Had their questions and concerns addressed	☐	Medicare Supplier Standards (Medicare Pt Only)	☐
A Home that has electrical outlets or adapters to support the DMEPOS	☐	Scope of Services	☐
Received a Home Assessment for Oxygen or Mobility (as applicable)	☐		

Setup and testing Info	☐ Assembly ☐ Battery Inserted ☐ Patient Sizing ☐ Item Programmed ☐ Other
	Product(s) functions according to Prescriber and Manuf. Guidelines: ☐ Yes ☐ No
	Product is structurally sound and meets the Manuf. Guidelines: ☐ Yes ☐ No

Individual Responsible for Dispensing/Setup Signature

ASSIGNMENT OF BENEFITS (MEDICARE ONLY)

☐ **Claim billed as assigned**

- I assign the right and responsibility to the Facility to bill on my behalf, and accept payment for Medicare DMEPOS products and services provided to me, the Beneficiary.
- I understand that I am responsible to pay any deductible amount applied to the claims and the coinsurance, which is 20 percent of the allowable or approved charge for a product or service.
- I permit the Facility to release and collect my health information, and other information, as required (and as permitted by the HIPAA Regulations) from my health care providers and Medicare receiving payment from Medicare.
- I understand that this form will be maintained and made available to Medicare or its representatives.

☐ **Claim billed as non-assigned**

ACKNOWLEDGEMENT OF RECEIPT (Proof of Delivery)

I acknowledge that I have received the DMEPOS product(s), complete instructions on the use, care, maintenance, and full documentation for the DMEPOS Product(s) listed above.

Patient/Caregiver Signature (Provide relationship if not the patient)	Date

Messages and Notes for Patient and /or Caregiver

PATIENT BILL OF RIGHTS AND RESPONSIBILITIES

To ensure the finest care possible, as a Patient receiving Durable Medical Equipment (DME) and our Facility services, you should understand your role, rights and responsibilities involved in your own plan of care.

Patient Rights

- To select those who provide you with DME and Facility services
- To receive the appropriate or prescribed services in a professional manner without discrimination relative to your age, sex, race, religion, ethnic origin, sexual preference or physical or mental handicap
- To be treated with friendliness, courtesy and respect by each and every individual representing our Facility, who provided treatment or services for you and be free from neglect or abuse, be it physical or mental
- To assist in the development and preparation of your plan of care that is designed to satisfy, as best as possible, your current needs, including management of pain
- To be provided with adequate information from which you can give your informed consent for commencement of services, the continuation of services, the transfer of services to another health care provider, or the termination of services
- To express concerns, grievances, or recommend modifications to your DME and Facility services, without fear of discrimination or reprisal
- To request and receive complete and up-to-date information relative to your condition, treatment, alternative treatments, risk of treatment or care plans
- To receive treatment and services within the scope of your plan of care, promptly and professionally, while being fully informed as to our Facility's policies, procedures and charges
- To request and receive data regarding treatment, services, or costs thereof, privately and with confidentially
- To be given information as it relates to the uses and disclosure of your plan of care
- To have your plan of care remain private and confidential, except as required and permitted by law

Patient Responsibilities

- To provide accurate and complete information regarding your past and present medical history
- To agree to a schedule of services and report any cancellation of scheduled appointments and/or treatments
- To participate in the development and updating of a plan of care
- To communicate whether you clearly comprehend the course of treatment and plan of care
- To comply with the plan of care and clinical instructions
- To accept responsibility for your actions, if refusing treatment or not complying with, the prescribed treatment and services
- To respect the rights of Facility personnel
- To notify your Physician and the Facility with any potential side effects and/or complications