PATIENT NAME:

IT IS REQUIRED THAT YOU COMPLETE AND RETURN THIS FORM TO MARK DRUG

Orientation Form

Mark Drug Medical Supply- 548A West Dundee Road, Wheeling, IL 60090- 847-537-8500- Fax 847-537-9430

Please read and initial where indicated:

Privacy Notice- We are committed to preserving the privacy of your personal health information. In fact, we are required by law to protect the privacy of your medical information and provide you with a notice describing how we use your health information for your treatment, obtaining payment, administrative purposes and evaluation.

I confirm that I have received a copy of "Notice of Privacy Practices" INITIAL HERE _____

Responsibilities of the Patient- I hereby guarantee payment to Mark Drug Medical Supply of any and all charges not covered by this assignment and waive any and all notices and demands in the event of non-payment there under. Mark Drug Medical Supply will bill me for my deductible and co-pay charges on equipment and/or supplies that I have received or rented.

I confirm that I have received a copy of "Responsibilities of the Patient" INITIAL HERE _____

Medicare Supplier Standards- We are committed to high standards at Mark Drug Medical Supply and are proud to assure you that we comply with all twenty-one Medicare Supplier Standards.

I confirm that I have received a copy of "Medicare Supplier Standards" INITIAL HERE _____

Patient Bill of Rights- As an individual receiving home healthcare services from Mark Drug Medical Supply, let it be known and understood you have rights.

I confirm that I have received a copy of "Patient Bill of Rights" INITIAL HERE _____

Protocol for Complaint Resolution- The patient has a right to freely voice grievances and recommend changes in care or services without fear of reprisal or unreasonable interruption of service.

I confirm having received a copy of "Protocol for Complaint Resolution" INITIAL HERE _____

Infection Control Information- The patient has received information on "Clean Hands Saves Lives" supplied by the CDC. Additional information can be found on their website: www.cdc.gov

I confirm having received a copy of "Infection Control Information" INITIAL HERE _____

Assignment of Benefits- I certify that the information given by me is correct. I request that payment of authorized benefits be made to me or on my behalf. I assign the benefits payable for covered services rendered by Mark Drug Medical Supply and authorize them to submit claims to Medicare, Medicaid and/or commerical insurance carriers for payment. My insurance benefits may be paid direct to Mark Drug Medical Supply, or to myself, based on claim(s) submitted.

You have received the following equipment or supplies: _____

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I attest, I have not received the same or similar equipment in the past. INITIAL HERE _____

Additional Forms or information provided to the patient as indicated:

Equipment instructions (paper)_____ Warranty information_____ On hand instruction_____ Company Phone number __X___
Detailed delivery ticket for products received _____ Capped rental information _____ Advanced Beneficiary Notice (ABN) _____

Assessment- Home: Any safety or health hazards_____
Ambulation: Normal _____ With assistance _____ Non-ambulatory _____
Senses Impaired: Hearing _____ Sight _____ Speech _____ Comments _____
Caregiver: Lives alone _____ Spouse _____ Live-in _____ Visiting _____ How often? _____

Plan of Service- Client Needs/Problems: Unable to use _____ Home safety _____ Follow-up services needed _____
Expected Outcomes: Will use as prescribed _____ Understand safety & product instructions _____
Other Services Needed: Routine follow-up _____ Emergency follow-up _____ Other _____

PLEASE SIGN & DATE

X_____ X_____ X_____

Patient Signature **Date** **Staff: STEPHEN**