INHEALTH
TECHNOLOGIES®

PATIENT ENROLLMENT FORM

IMPORTANT: This form needs to be submitted only one time unless information has changed.

1110 Mark Avenue • Carpinteria, CA 93013 • Tel: (800) 477-5969 • (805) 684-9337 • medicare@inhealth.com • www.inhealth.com

SECTION A: PATIENT INFORMATION

Name:

Address:

City: State: Zip:

Telephone: Email Address:

Date of Birth: Last 4 Digits of SSN:

Diagnosis for Service Provided:

Is Client/Patient in a Hospital, Home Care or Care Facility? ☐ Y ☐ N If Yes, Start Date:

Emergency Contact: Telephone:

Caregiver (if applicable): Telephone:

SECTION B: PHYSICIAN INFORMATION

Ordering / Prescribing Physician Name:

Telephone: FAX:

SECTION C: PRIMARY INSURANCE INFORMATION

PLEASE SUBMIT A COPY OF INSURANCE CARDS, FRONT AND BACK.

☐ **I would like to enroll in Medicare Assignment** (This program is for customers with Medicare as their primary insurance payer) For more information about Medicare Assignment, please visit InHealth.com and go to Medicare Assignment, under the Resources tab.

Insurance Company/Plan Name: Telephone:

Medicare/ Policy/ Member ID Number: Group Number:

Claim Address:

Name of Insured (if not self): Date of Birth:

Relation to Insured: ☐Self ☐Spouse ☐ Child ☐Other: Condition Related to: ☐ Employment ☐Accident

SECTION D: SECONDARY INSURANCE INFORMATION

PLEASE SUBMIT A COPY OF INSURANCE CARDS, FRONT AND BACK.

Insurance Company/Plan Name: Telephone:

Medicare/ Policy/ Member ID Number: Group Number:

Claim Address:

Name of Insured (if not self): Date of Birth:

Relation to Insured: ☐Self ☐Spouse ☐ Child ☐Other: Condition Related to: ☐ Employment ☐Accident

CLIENT/PATIENT SERVICE AGREEMENT/PLAN OF SERVICE

Authorization/Consent for Care/Service: I have been informed of the home care options available to me and of the selection of providers from which I may choose. I authorize InHealth Technologies, a Division of Freudenberg Medical, LLC, under the direction of the prescribing physician, to provide home medical equipment, supplies and services as prescribed by my physician. I understand and have been properly trained by my doctor or Speech Language Pathologist on using the products prescribed to me.

Assignment of Benefits/Authorization for Payment: I authorize InHealth Technologies, a Division of Freudenberg Medical, LLC, to seek benefits and payments on my behalf. It is understood that, as a courtesy InHealth Technologies, a Division of Freudenberg Medical, LLC, will bill Medicare. 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 InHealth Technologies, a Division of Freudenberg Medical, LLC, within 30 days of the event.
I have been informed by InHealth Technologies, a Division of Freudenberg Medical, LLC, of the medical necessity for the services prescribed by my physician. I understand that in the event services are deemed not reasonable and necessary, payment may be denied and that I will be fully responsible for payment.

Release of Information: I hereby request and authorize InHealth Technologies, a Division of Freudenberg Medical, LLC, the prescribing physician, hospital, and any other holder of information relevant to service, to release information upon request to InHealth Technologies, a Division of Freudenberg Medical, LLC, any payer source, physician, or any other medical personnel or agency involved with service. I also authorize InHealth Technologies, a Division of Freudenberg Medical, LLC, to review medical history and payer information for the purpose of providing home health care.

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, out-of-pocket requirements, and non-covered services. If for any reason and to any extent, InHealth Technologies, a Division of Freudenberg Medical, LLC, does not receive payment from my payer source, I hereby agree to pay InHealth Technologies, a Division of Freudenberg Medical, LLC, for the balance in full, within 30 days of receipt of invoice. All charges not paid within 45 days of billing date shall be assessed late charges. I am liable for all charges, including collection costs and all attorney costs. I am responsible for all charges regardless of my payer unless my agreement with my health plan holds me harmless.

Returned Goods: I understand that due to Federal and State Pharmacy Regulations, ancillary items prescribed for home health care cannot be re-dispensed. Therefore, ancillary items cannot be returned for credit. Home Medical Equipment that is rented will be returned after the physician has discontinued service. Sale items cannot be returned. InHealth Technologies, a Division of Freudenberg Medical, LLC, 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.

Client/Patient Handouts: I acknowledge that I have received a copy of the Client/Patient Handouts which contains Client/Patient Rights and Responsibilities, Supplier Standards, Home Safety Information, HIPAA Privacy Standards, Emergency Planning, and Advance Directive Information. I acknowledge that the information in the Client/Patient Handouts has been explained to me and that I understand the information. I understand my right to formulate and to issue Advance Directives to be followed should I become incapacitated. I will furnish InHealth Technologies, a Division of Freudenberg Medical, LLC, with a copy of such document.

Grievance 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. I understand that I may lodge a complaint without concern for reprisal, discrimination, or unreasonable interruption of service. To place a grievance, please call 800-477-5969 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. Office of Inspector General Department of Health and Human Services: 1-800-HHS-TIPS (1-800-447- 8477). To reach our accrediting body, please call Accreditation Commission for Health Care (ACHC): 919-785-1214.

Home Health Hotline: You may also make inquiries or complaints about this company by calling your local Social Services Department and/or ACHC.

Change of Insurance: I understand I must notify InHealth Technologies by phone, United States mail, or e-mail immediately if my insurance coverage changes in any way or I begin receiving any Home Health services AFTER returning these forms. If InHealth Technologies is not notified immediately upon enrollment, they will not be responsible for refunding any unpaid Medicare claims to me.

Plan of Service: Identified needs/problems: The patient may be 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. The patient will use products in accordance with instructions for use.

All client/patients receiving services from InHealth Technologies should be informed of their rights, available on our website. Please visit InHealth.com and go to the Forms page.

Sign Below:

***By signing below,** you are agreeing to receive telephone, written and electronic communications from InHealth Technologies via the telephone number, mailing address, email address and/or electronic application profile information you have provided, including information regarding your products and orders. You are also agreeing to receive company information, product updates and promotions from our Marketing Team. Please notify us if you wish to opt-out from receiving marketing communications.

***By signing below,** you are confirming you have reviewed the Patient Bill of Rights & Terms and Conditions.

Client / Patient Signature:_____ Date:_____

Please return this form upon completion.

Mail: InHealth Technologies • 1110 Mark Avenue • Carpinteria, CA 93013 Email: medicare@inhealth.com
Fax: (734) 354-5757