

HIPAA NOTICE OF PRIVACY PRACTICES
As required by the Privacy Regulations Promulgated Pursuant to the
Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by our organization, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the organization, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for equipment or supplies coverage may require that your relevant protected health information be disclosed to the health plan to obtain approval for coverage.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of our organization. These activities include, but are not limited to, quality assessment activities, employee review activities, accreditation activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to accrediting agencies as part of an accreditation survey. We may also call you by name while you are at our facility. We may use or disclose your protected health information, as necessary, to contact you to check the status of your equipment.

We may use or disclose your protected health information in the following situations without your authorization: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Criminal Activity, Inmates, Military Activity, National Security, and Workers' Compensation. Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to object, unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or this organization has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Our organization is not required to agree to a restriction that you may request. If our organization believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, e.g., electronically.

You may have the right to have our organization amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information, if you have any questions concerning or objections to this form, please ask to speak with our President in person or by phone at 972-380-2065.

Associated companies with whom we may do business, such as an answering service or delivery service, are given only enough information to provide the necessary service to you. No medical information is provided.

We welcome your comments: Please feel free to call us if you have any questions about how we protect your privacy. Our goal is always to provide you with the highest quality services. This notice was published and becomes effective on/or before April 14, 2003

EMERGENCY PLANNING FOR THE HOME CARE CLIENT/PATIENT

This pamphlet has been provided by Star Medical Specialties to help you plan your actions in case there is a natural disaster where you live. Many areas of the United States are prone to natural disasters like hurricanes, tornadoes, floods, and earthquakes.

Every client/patient receiving care or services in the home should think about what they would do in the event of an emergency. Our goal is to help you plan so that we can try to provide you with the best, most consistent service we can during the emergency.

Know What to Expect

If you have recently moved to this area, take the time to find out what types of natural emergencies have occurred in the past, and what types might be expected.

Find out what, if any, time of year these emergencies are more prevalent.

Find out when you should evacuate, and when you shouldn't.

Your local Red Cross, local law enforcement agencies, local news and radio stations usually provide excellent information and tips for planning.

Know Where to Go

One of the most important pieces of information you should know is the location of the closest emergency shelter.

These shelters are opened to the public during voluntary and mandatory evacuation times. They are usually the safest place for you to go, other than a friend or relative's home in an unaffected area.

Know What to Take with You

If you are going to a shelter, there will be restrictions on what items you can bring with you. Not all shelters have adequate storage facilities for medications that need refrigeration.

We recommend that you call ahead and find out which shelter in your area will let you bring your medications and medical supplies, in addition, let them know if you will be using medical equipment that requires an electrical outlet.

During our planning for a natural emergency, we will contact you and deliver, if possible, at least one week's worth of medication and supplies. Bring all your medications and supplies with you to the shelter.

Reaching Us if There Are No Phones

How do you reach us during a natural emergency if the phone lines don't work? How would you contact us? If there is warning of the emergency, such as a hurricane watch, we will make every attempt to contact you and provide you with the number of our cellular phone. (Cellular phones frequently work even when the regular land phone lines do not.)

If you have no way to call our cellular phone, you can try to reach us by having someone you know call us from his or her cellular phone. (Many times cellular phone companies set up communication centers during natural disasters. If one is set up in your area, you can ask them to contact us.)

If the emergency was unforeseen, we will try to locate you by visiting your home, or by contacting your home nursing agency. If travel is restricted due to damage from the emergency, we will try to contact you through local law enforcement agencies.

An Ounce of Prevention...

We would much rather prepare you for an emergency ahead of time than wait until it has happened and then send you the supplies you need.

To do this, we need for you to give us as much information as possible before the emergency. We may ask you for the name and phone number of a close family member, or a close friend or neighbor. We may ask you where you will go if an emergency occurs. Will you go to a shelter, or a relative's home? If your doctor has instructed you to go to a hospital, which one is it?

Having the address of your evacuation site, if it is in another city, may allow us to service your therapy needs through another company.

Helpful Tips

- Get a cooler and ice or freezer gel-packs to transport your medication.
- Get all of your medication information and teaching modules together and take them with you if you evacuate.
- Pack one week's worth of supplies in a plastic-lined box or waterproof tote bag or tote box. Make sure the seal is watertight.
- Make sure to put antibacterial soap and paper towels into your supply kit.
- If possible, get waterless hand disinfectant from Star Medical Specialties or from a local store. It comes in very handy if you don't have running water.
- If you are going to a friend or relative's home during evacuation, leave their phone number and address with Star Medical Specialties and your home nursing agency.
- When you return to your home, contact your home nursing agency and Star Medical Specialties so we can visit and see what supplies you need.

For More information

There is much more to know about planning for and surviving during a natural emergency or disaster.

To be ready for an emergency, contact your local American Red Cross or Emergency Management Services agency.

An Important Reminder!!

*During any emergency situation, if you are unable to contact our company and you are in need of your prescribed medication, equipment or supplies, **you must go to the nearest emergency room or other treatment facility for treatment.***

ADVANCE DIRECTIVES MAKING DECISIONS ABOUT YOUR HEALTH CARE

Advance Directives are forms that say, in advance, what kind of treatment you want or don't want under serious medical conditions. Some conditions, if severe, may make you unable to tell the doctor how you want to be treated at that time. Your Advance Directives will help the doctor to provide the care you would wish to have.

Most hospitals and home health organizations are required to provide you with information on Advance Directives. Many are required to ask you if you already have Advance Directives prepared.

This pamphlet has been designed to give you information and may help you with important decisions. Laws regarding Advance Directives vary from state to state. We recommend that you consult with your family, close friends, your physician, and perhaps even a social worker or lawyer regarding your individual needs and what may benefit you the most.

What Kinds Of Advance Directives Are There?

There are two basic types of Advance Directives available. One is called a Living Will. The other is called a Durable Power of Attorney.

A Living Will gives information on the kind of medical care you want (or do not want) become terminally ill and unable to make your own decision.

- It is called a "Living" Will because it takes effect while you are living.
- Many states have specific forms that must be used for a Living Will to be considered legally binding. These forms may be available from a social services office, law office, or possibly a library.
- In some states, you are allowed to simply write a letter describing what treatments you want or don't want.
- In all cases, your Living Will must be signed, witnessed, and dated. Some states require verification.

A Durable Power of Attorney is a legal agreement that names another person (frequently a spouse, family member, or close friend) as an *agent* or *proxy*. This person would then be make medical decisions for you if you should become unable to make them for yourself. A Durable Power of Attorney can also include instructions regarding specific treatments that want or do not want in the event of serious illness.

What Type of Advance Directive is best for me?

This is not a simple question to answer. Each individual's situation and preferences are unique.

- For many persons, the answer depends on their specific situation, or personal desires for their health care.
- Sometimes the answer depends on the state in which you live. In some states, it is better to have one versus the other.
- Many times you can have both, either as separate forms or as a single combined form.

What Do I Do If I Want An Advance Directive?

- First, consult with your physician's office or home care agency about where to get information specific for your state.
- Once you have discussed the options available, consult with any family members or friends who may be involved in your medical care. This is extremely important if you have chosen a friend or family member as your "agent" in the Durable Power of Attorney.
- Be sure to follow all requirements in your state for your signature, witness signature, notarization (if required), and filing.
- You should provide copies of your Advance Directive(s) to people you trust, such as close family members, friends and/or caregiver(s). The original document should be filed in a secure location known to those to whom you give copies.
- Keep another copy in a secure location; if you have a lawyer, he or she will keep a copy as well.

How Does My Health Care Team Know I Have an Advance Directive?

You must tell them. Many organizations and hospitals are required to ask you if you have one. Even so, it is a good idea to tell your physicians and nurses that you have an Advance Directive, and where the document can be found.

Many client/patients keep a small card in their wallet that states the type of Advance Directive they have, where a copy of the document(s) is located, and a contact person, such as your Durable Power of Attorney "agent," and how to contact them.

What If I Change My Mind?

You can change your mind about any part of your Advance Directive, or even about having an Advance Directive, at any time.

If you would like to cancel or make changes to the document(s), it is very important that you follow the same signature, dating, and witness procedure as the first time, and that you make sure all original versions are deleted or discarded, and that all health care providers, your caregiver(s), your family and friends have a revised copy.

What If I Don't Want An Advance Directive?

You are not required by law to have one. Many home care companies are required to provide you with this basic information, but what you choose to do with it is entirely up to you.

For More Information...

This pamphlet has been designed to provide you with basic information. It is not a substitute for consultation with an experienced lawyer or knowledgeable social worker. These persons, or your home care agency, can best answer more detailed questions, and help guide you towards the best Advance Directive for you.

Star Medical Specialties
CLIENT/PATIENT HANDOUTS
CLIENT/PATIENT BILL OF RIGHTS AND RESPONSIBILITIES

We believe that all client/patients receiving services from Star Medical Specialties should be informed of their rights. Therefore, you are entitled to:

1. Receive reasonable coordination and continuity of services from the referring agency for home medical equipment services.
2. Receive a timely response from Star Medical Specialties when homecare services/care is needed or requested.
3. Be fully informed in advance about service/care to be provided and any modifications to the Plan of Service/Care.
4. Participate in the development and periodic revision of the Plan of service/care.
5. Informed consent and refusal of service/care or treatment after the consequences of refusing service/care or treatment are fully presented.
6. Be informed in advance of the charges, including payment for service/care expected from third parties and any charges for which the client/patient will be responsible.
7. Have one's property and person treated with respect, consideration, and recognition of client/patient dignity and individuality.
8. Be able to identify visiting staff members through proper identification.
9. Voice grievances/complaints or recommend changes in policy, staff or service/care without restraint, interference, coercion, discrimination or reprisal.
10. Choose a health care provider.
11. Confidentiality and privacy of all information contained in the client/patient record and of Protected Health Information.
12. Receive appropriate service/care without discrimination in accordance with physician orders.
13. Be informed of any financial benefits when referred to an organization.
14. Be fully informed of one's responsibilities.
15. Be informed of provider service/care limitations.
16. Be informed of client/patient rights under state law to formulate advance care directives.
17. Be informed of anticipated outcomes of service/care and of any barriers in outcome achievement.
18. Receive reasonable coordination and continuity of services from the referring agency for home medical equipment services
19. Receive a timely response from Star Medical Specialties when homecare services or care are needed or requested
20. Be fully informed in advance about service or care to be provided, and any modifications to the Plan of Service or the Plan of Care
21. Participate in the development and periodic revision of the Plan of Service or the Plan of Care

CLIENT RESPONSIBILITIES

1. Client agrees that rental equipment will be used with reasonable care, not altered or modified, and returned in good condition (normal wear and tear excepted).
2. Client agrees to promptly report to Star Medical Specialties any malfunctions or defects in rental equipment so that repair/ replacement can be arranged.
3. Client agrees to provide Star Medical Specialties access to all rental equipment for repair/replacement, maintenance, and/or pick-up of the equipment.
4. Client agrees to use the equipment for the purposes so indicated and in compliance with the physician's prescription.
5. Client agrees to keep the equipment in their possession and at the address to which it was delivered unless otherwise authorized by Star Medical Specialties

6. Client agrees to notify Star Medical Specialties of any hospitalization, change in customer insurance, address, telephone number, physician, or when the medical need for the rental equipment no longer exists.
7. Client agrees to request payment of authorized Medicare, Medicaid, or other private insurance benefits are paid directly to Star Medical Specialties for any services furnished by Star Medical Specialties.
8. Client agrees to accept all financial responsibility for home medical equipment furnished by Star Medical Specialties
9. Client agrees to pay for the replacement cost of any equipment damaged, destroyed, or lost due to misuse, abuse or neglect.
10. Client agrees not to modify the rental equipment without the prior consent of Star Medical Specialties
11. Client agrees that any authorized modification shall belong to the titleholder of the equipment unless equipment is purchased and paid for in full.
12. Client agrees that title to the rental equipment and all parts shall remain with Star Medical Specialties at all times unless equipment is purchased and paid for in full.
13. Client agrees that Star Medical Specialties shall not insure or be responsible to the client for any personal injury or property damage related to any equipment; including that caused by use or improper functioning of the equipment; the act or omission of any other third party, or by any criminal act or activity, war, riot, insurrection, fire or act of God
14. Client understands that Star Medical Specialties retains the right to refuse delivery of service to any client at any time.
15. Client agrees that any legal fees resulting from a disagreement between the parties shall be borne by the unsuccessful party in any legal action taken.

When the client/patient is unable to make medical or other decisions, the family should be consulted for direction.

All staff members will understand and be able to discuss the Client Bill of Rights and Responsibilities with the client/patient and caregiver(s). Each staff member will receive training during orientation and attend an annual in-service education class on the Client Bill of Rights and Responsibilities.

The client/patient and caregiver(s) will also receive a copy of the DMEPOS Supplier Standards, which is included in the Client/Patient Handouts forms.

Star Medical Specialties

CLIENT/PATIENT SERVICE AGREEMENT

Client/Patient Name: _____ ID _____

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 Star Medical Specialties under the direction of the prescribing physician, to provide home medical equipment, supplies and services as prescribed by my physician.

Assignment of Benefits/Authorization for Payment: I hereby assign all benefits and payments to be made directly to Star Medical Specialties, Inc for any home medical equipment, supplies and services furnished to me in conjunction with my home care. I authorize Star Medical Specialties to seek such benefits and payments on my behalf. It is understood that, as a courtesy, Star Medical Specialties will bill Medicare/Medicaid or other federally funded sources and other payors and insurer(s) providing coverage, with a copy to Star Medical Specialties 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 Star Medical Specialties within 30 days of the event. I have been informed by Star Medical Specialties 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 Star Medical Specialties, the prescribing physician, hospital, and any other holder of information relevant to service, to release information upon request, to Star Medical Specialties, any payor source, physician, or any other medical personnel or agency involved with service. I also authorize Star Medical Specialties to review medical history and payor information for the purpose of providing home health care.

Financial Responsibility: I understand and agree that I am responsible for the payment of 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, Star Medical Specialties does not receive payment from my payor source, I hereby agree to pay Star Medical Specialties 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's costs. I am responsible for all charges regardless of my payor 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. Star Medical Specialties 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, HIPPA 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 Star Medical Specialties with a copy of such document.

Grievance Reporting: I acknowledge that I have been informed of the procedure to report 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 972-380-2065 and speak to the Customer Services Supervisor. If your complaint is not resolved to your satisfaction within 5 working days, you may initiate formal grievance in writing and forward it to the Governing Body. You can expect a written response within 7 working days or receipt.

Home Health Hotline: You may also make inquiries or complaints about this company by calling your local Social Services Department and/or HQAA. **HHS-TIPS HOTLINE: 1-800-447-8477, Mon – Fri, 8am-5:30pm EST. HQAA: (866) 684-7911, 24 hours.**

Client/patient: _____ Date: _____

Witness: _____ Date: _____

Form revised: 08/20/2010

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Star Medical Specialties
DFW and El Paso, Texas
Albuquerque, New Mexico

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We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Criminal Activity, inmates, Military Activity, National Security, and Workers' Compensation. Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or this organization has taken an action in reliance on the use or disclosure indicated in the authorization.

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You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

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This notice was published and becomes effective on/or before April 14, 2003

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information, if you have any questions concerning or objections to this form, please ask to speak with our HIPAA Compliance Officer (General Manager) in person or by phone at 972-380-2065.

Your signature below acknowledges that you have received a copy of this Notice of our Privacy Practices.

Print Name: _____

Date: _____

Signature: _____

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Form Revised: 08/20/2007

Star Medical Specialties

EQUIPMENT MANAGEMENT ADMISSION ASSESSMENT AND PLAN OF SERVICE

CLIENT NAME _____ ADMISSION DATE _____

ADDRESS _____

PHONE _____ EMERGENCY CONTACT _____

SEX _____ DATE OF BIRTH _____ HOSPITAL D/C DATE _____

DIAGNOSIS _____ PHYSICIAN _____

PHYSICIAN'S ORDERS _____

OTHER INDIVIDUALS/ORGANIZATIONS INVOLVED IN CLIENT'S CARE: _____

HOME ASSESSMENT-ENVIRONMENTAL/SAFETY/FALLS

ARCHITECTURAL BARRIERS	<input type="checkbox"/> ADEQUATE	<input type="checkbox"/> INADEQUATE
SHELTER, HEAT, WATER, PLUMBING, REFRIGERATION, COOKING	<input type="checkbox"/> ADEQUATE	<input type="checkbox"/> INADEQUATE
ELECTRICAL (check ground, no use of extension cords)	<input type="checkbox"/> ADEQUATE	<input type="checkbox"/> INADEQUATE
FIRE SAFETY (has smoke detector/alarm and extinguisher)	<input type="checkbox"/> ADEQUATE	<input type="checkbox"/> INADEQUATE
DOES ANYONE SMOKE IN THE HOME? _____	NUMBER PERSONS LIVING IN HOME? _____	

FALLS ASSESSMENT COMPLETED AND CDC HANDOUTS REVIEWED? YES NO
 ANY FALLS HAZARDS DETERMINED DURING ASSESSMENT? YES NO, IF YES, DOCUMENT CONCERNS AND INFORMATION GIVEN THE CLIENT: _____

ANY OTHER SAFETY OR HEALTH HAZARDS? COMMENTS: _____

SUITABLE FOR HOME CARE? YES NO, IF NO, DOCUMENT CONCERNS AND INFORMATION GIVEN THE CLIENT: _____

EQUIPMENT INFORMATION

1. Manufacturer: _____ Model: _____ Serial #: _____

Hours: _____ Setting(s): _____

Next PM Due: Date _____ Hours: _____ PM Sticker Present: Yes No

2. Manufacturer: _____ Model: _____ Serial #: _____

Hours: _____ Setting(s): _____

Next PM Due: Date _____ Hours: _____ PM Sticker Present: Yes No

3. Manufacturer: _____ Model: _____ Serial #: _____

Hours: _____ Setting(s): _____

Next PM Due: Date _____ Hours: _____ PM Sticker Present: Yes No

4. Manufacturer: _____ Model: _____ Serial #: _____

Hours: _____ Setting(s): _____

Next PM Due: Date _____ Hours: _____ PM Sticker Present: Yes No

SUPPLIES DISPENSED

PLAN OF SERVICE

Identified Needs/Problems:

The client is unfamiliar with use and maintenance of the home medical equipment.

- The client is uncertain of home safety.
- The client may be required to troubleshoot the equipment or use back-up equipment.
- The client may require follow-up services.

Expected Outcomes:

- The client will be provided prescribed equipment to comply with the physician's prescription.
- The client will use the home medical equipment as prescribed by the physician.
- The client will use and maintain home medical equipment in a safe/proper manner.
- The client will adhere to home safety guidelines.
- The client will be able to troubleshoot any equipment problems and/or use back-up system.
- The client will know how to obtain follow-up services as needed.

Services/Actions Provided:

- Deliver and set-up home medical equipment at a mutually agreed upon time and place.
- Provide training in safe/proper use and maintenance of all home medical equipment.
- Provide training and written handout in client rights and responsibilities, supplier standards, home safety, HIPPA Privacy standards, emergency planning and provide financial responsibilities
- Demonstrate troubleshooting of equipment and correct use of back-up system (if provided).
- Provide written instructions for use of the home medical equipment.
- Provide written instructions for obtaining routine/emergency follow-up services
- For equipment sold to the client the warranty card(s) are given to the client. Mark NA if no sale items are provided

I acknowledge training in the use of equipment and products provided and the performance of the Equipment Management Admission Assessment and Plan of Service on the date noted: **I have been instructed to call 972-380-2065 for Star Medical Specialties after hours.**

Form Revised:10/16/2013

Client/Patient Signature
10/14/2013

Date

Staff Member

Form Revised:



EQUIPMENT WARRANTY INFORMATION FORM

Date: _____

Name of the Patient: _____

Every product sold or rented by Star Medical Specialties carries a 2-year manufacturer's warranty. We notify all Medicare/Medicaid beneficiaries of the warranty coverage, and that we honor all warranties under applicable law. We will repair or replace, free of charge, Medicare/Medicaid covered equipment that is under warranty. In addition, an owner's manual with warranty information will be provided to beneficiaries for all durable medical equipment where this manual is available.

I have been instructed and understand the warranty coverage of the product I have received.

Beneficiary's Signature: _____

Date: _____



RELEASE OF INFORMATION

Date: _____

Name of the Patient: _____

Relationship to the Patient: _____

I, _____ (patient)/ (guardian) have read and understand the HIPPA policies and authorize *Star Medical Specialties* to discuss my account, medical and/or financial, with the following people:

Name

Relationship to Patient

Name

Relationship to Patient

Name

Relationship to Patient

Person to contact in case of emergency:

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

Patient's Signature: _____