

LIFETIME AUTHORIZATION / ASSIGNMENT OF BENEFITS

PATIENT: _____ INSURED'S NAME: _____

PRIMARY POLICY #: _____ GROUP #: _____

SECONDARY POLICY #: _____ GROUP #: _____

I hereby instruct and direct my Insurance Company (s) make payments payable to and remit to the following address:

**ATTENTION DIABETICS, INC.
129 SOUTH WATER AVENUE
GALLATIN, TENNESSEE 37066**

for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. If my current policy prohibits direct payment to the provider, then I hereby also instruct and direct you to make out the check to me and mail to the above address. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee and I have agreed to pay, in a current manner any balance of said professional service charges over and above the insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any medical information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

I authorize the provider to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

_____ Signature of Policy Holder	_____ Date
_____ Signature of Claimant, if other than the Policyholder	_____ Date
_____ Beneficiary Signature if patient is unable to sign	_____ Date
_____ Beneficiary's relation to patient	_____ Reason patient is unable to sign

I acknowledge that I have received a copy of ATTENTION Diabetics, Inc.'s NOTICE OF PRIVACY PRACTICES.

I acknowledge that I have received a copy of the CMS MEDICARE DMEPOS SUPPLIER STANDARDS.

MEDICARE LIFETIME AUTHORIZATION / ASSIGNMENT OF BENEFITS

I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carrier any information needed for this or related Medicare Insurance claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits be made to the party who accepts assignment on any bills for services furnished to me. I understand that I will be financially responsible for my yearly Medicare deductible and 20% co-insurance. Furthermore, I accept responsibility for any and all medical equipment / supplies while in my possession.

Patient's Signature

Date

ATTENTION DIABETICS, INC.

NOTICE OF PRIVACY PRACTICES

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.

1. **Our responsibility to safeguard your protected health information.**

We are required by law to provide you with this notice our privacy practices that explains how, when, and why we use and disclose your protected health information. With some exceptions, we may not use or disclose any more than the minimum necessary protected health information to accomplish the purpose of the use or disclosure. We are legally required to follow the privacy practices that are described in this notice.

However, we reserve the right to change the terms of this notice and our privacy practices at any time. Any changes will apply to the protected health information we already have. Before we make an important change to our policies , we will promptly change this notice. You can request a copy of this notice at the address listed below at any time.

2. **How your protected health information may be used.**

A. We use health information about you for treatment purposes, to obtain payment for treatment, and for healthcare operations such as evaluating the quality of care that you receive.

For some of these uses or disclosures, we need your prior consent. Below we describe the different categories for our uses and disclosures that need your consent and give you some examples of each category.

- **For treatment.** For example: Information obtained by a nurse, physician, or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. We will also provide your physician or a subsequent healthcare provider with copies of various reports that should assist him or her in treating you.
- **To obtain payment for treatment.** We may use and disclose your protected health information in order to bill and collect payment for the services provided to you. For example, we may provide portions of your protected health information to our billing department and your health plan to get paid for the services we provided to you. We may also provide your protected health information to our business associates, such as billing companies, claims processing companies, and others that process our health care claims.
- **For health care operations.** Members of our staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the care and services we provide.

B. There are certain uses and disclosures that do not require your consent.

We may use and disclose your protected health information without your consent or authorization for the following reasons:

- **When a disclosure is required by federal, state or local law, judicial or administrative proceedings, or law enforcement.** For example, we make disclosures when a law requires that we report information to government agencies and law enforcement personnel about victims of abuse, neglect, or domestic violence; when dealing with a gunshot and other wounds; or when ordered in a judicial or administrative proceeding.
- **For public health activities.**
- **For health oversight activities.** For instance, we will provide information to assist the government when it conducts an investigation or inspection of a health care provider or organization.
- **For purposes of organ donation.**
- **For research purposes.**
- **To avoid harm.** In order to avoid a serious threat to the health and safety of a person or the public, we may provide patient protected health information to law enforcement personnel or persons able to prevent or lessen such harm.
- **For specific government functions.** We may disclose patient protected health information of military personnel and veterans in certain situations. And we may disclose patient protected health information for national security purposes, such as protecting the president of the United States or conducting intelligence operations.
- **For workers' compensation purposes.** We may provide patient protected health information in order to comply with workers' compensation laws.

- **Appointment reminders and health-related benefits or services.** We may use protected health related information to provide appointment reminders or give you information about treatment alternatives, or health care services or benefits we offer.
- **Fundraising activities.** We may use patient protected health information to raise funds for our organization. The money raised through these activities is used to expand and support the health care services and educational programs we provide to the community. If you do not wish to be contacted as part of our fund raising efforts, please contact the person in section V below.

C. There are certain uses and disclosures to which you will have the opportunity to object.

In the following situations we may disclose your protected health information if we inform you about the disclosure in advance and you do not object. If there is an emergency and you cannot be given the opportunity to object, we may disclose your health information consistent with any prior expressed wishes if it is determined by a healthcare professional that it is in your best interest. If you are unable to consent in an emergency, you will be given the opportunity to object as soon as you are able to do so.

- **Disclosures to family, friends, or others.** We may provide your protected health information to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part.

All other uses and disclosures require your prior written authorization. In any other situation not described previously we will ask for your written authorization before using or disclosing any of your protected health information. If you choose to sign an authorization to disclose your protected health information, you can later revoke that authorization in writing to stop any future uses and disclosures (to the extent that we haven't already taken any action relying on the authorization).

3. Your rights regarding your protected health information.

- You have the right to ask that we limit how we use and disclose your protected health information. We will consider your request but are not legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosure that we are legally required or allowed to make.
- You have the right to ask that we send information to you to an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail). We must agree to your request so long as we can easily provide it in the format you requested.
- In most cases, you have the right to look at or get copies of your protected health information that we have, but you must make the request in writing. If we do not have your protected health information but we know who does, we will tell you how to get it. We will respond to you within 30 days after receiving your written request. In certain situations, we may deny your request, if we do, we will tell you, in writing, our reasons for the denial and explain your right to have the denial reviewed.

If you request copies of your protected health information, we will charge you a nominal fee for each page. Instead of providing the protected health information you requested, we may provide you with a summary or explanation of the information as long as you agree to that and to the cost in advance.

- You have the right to get a list of instances in which we have disclosed your protected health information. The list will not include uses or disclosures that you have already consented to, such as those made for treatment, payment, or health care operations, directly to you, to your family, or in our facility directly. The list also will not include uses and disclosures made for national security purposes, to corrections or law enforcement personnel, or before April 14 2003.

We will respond within 60 days of receiving your request. The list we will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date of the disclosure, to whom your protected health information was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. We will provide the list to you at no charge, but if you make more than one request in the same 12 month period, we will charge you a nominal fee for each additional request.

- If you think there is a mistake in your protected health information or that a piece of important information is missing, you have the right to request that we correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. We will respond in 60 days of receiving

your request. We may deny your request in writing if the protected health information is (1) correct and complete, (2) not created by us, (3) not allowed to be disclosed, or (4) not part of our records. Our written denial will state the reasons for the denial and explain your right to file a written statement or disagreement with the denial. If you do not file one, you have the right to request your request and our denial be attached to all future disclosures of your protected health information. If we approve your request, we will make the change to your protected health information, tell you that we have done it, and others that need to know about the change to your protected health information.

- You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of this notice.

4. How to complain about our privacy practices.

If you think that we have violated your privacy rights, or you disagree with a decision we made about access to your protected health information, you may file a complaint with the person listed in Section 5 below. You may also send a written complaint to the Secretary of the Department of Health and Human Services at the following address.

Secretary of the Department of Health and Human Services
The U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201
Toll Free: (877) 696-6775

We will take no retaliatory action against you if you file a complaint about our privacy practices.

5. Person to contact for information about this notice or to complain about our privacy practices.

If you have any questions about this notice or any complaints about our privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Resources, please contact Dave Swatzell at 888-775-3001, 129 S. Water Ave., Gallatin, TN 37066.

6. Effective date of this notice.

This notice went into effect on April 14, 2003.

CMS MEDICARE DMEPOS SUPPLIER STANDARDS

Note: This list is an abbreviated version of the application certification standards, that every Medicare DMEPOS supplier must meet in order to obtain and retain their billing privileges. These standards, in their entirety, are listed in 42 C.F.R. pt. 424, sec 424.57© and are effective on December 11, 2000. A supplier must disclose these standards to all customers/patients who are Medicare beneficiaries (standard 16).

1. A supplier must be in compliance with all applicable Federal and State licensure and regulatory requirements.
2. A supplier must provide complete and accurate information on the DMEPOS supplier application. Any changes to this information must be reported to the National Supplier Clearinghouse within 30 days.
3. An authorized individual (one whose signature is binding) must sign the application for billing privileges.
4. A supplier must fill orders from its own inventory, or must contract with other companies for the purchase of items necessary to fill the order. A supplier may not contract with any entity that is currently excluded from the Medicare program, any State health care programs, or from any other Federal procurement or non-procurement programs.
5. A supplier must advise beneficiaries that they may rent or purchase inexpensive or routinely purchased durable medical equipment, and of the purchase option for capped rental equipment.
6. A supplier must notify beneficiaries of warranty coverage and honor all warranties under applicable State law, and repair or replace free of charge Medicare covered items that are under warranty.
7. A supplier must maintain a physical facility on an appropriate site.
8. A supplier must permit CMS (formerly HCFA), or its agents to conduct on-site inspections to ascertain the supplier's compliance with these standards. The supplier location must be accessible to beneficiaries during reasonable business hours, and must maintain a visible sign and posted hours of operation.
9. A supplier must maintain a primary business telephone listed under the name of the business in a local directory or a toll free number available through directory assistance. The exclusive use of a beeper, answering machine or cell phone is prohibited.
10. A supplier must have comprehensive liability insurance in the amount of at least \$300,000 that covers both the supplier's place of business and all customers and employees of the supplier. If the supplier manufactures its own items, this insurance must also cover product liability and completed operations.
11. A supplier must agree not to initiate telephone contact with beneficiaries, with a few exceptions allowed. This standard prohibits suppliers from calling beneficiaries in order to solicit new business.
12. A supplier is responsible for delivery and must instruct beneficiaries on use of Medicare covered items, and maintain proof of delivery.
13. A supplier must answer questions and respond to complaints of beneficiaries, and maintain documentation of such contacts.
14. A supplier must maintain and replace at no charge or repair directly, or through a service contract with another company, Medicare-covered items it has rented to beneficiaries.
15. A supplier must accept returns of substandard (less than full quality for the particular item) or unsuitable items (inappropriate for the beneficiary at the time it was fitted and rented or sold) from beneficiaries.
16. A supplier must disclose these supplier standards to each beneficiary to whom it supplies a Medicare-covered item.
17. A supplier must disclose to the government any person having ownership, financial, or control interest in the supplier.
18. A supplier must not convey or reassign a supplier number; i.e., the supplier may not sell or allow another entity to use its Medicare billing number.
19. A supplier must have a complaint resolution protocol established to address beneficiary complaints that relate to these standards. A record of these complaints must be maintained at the physical facility.
20. Complaint records must include: the name, address, telephone number and health insurance claim number of the beneficiary, a summary of the complaint, and any actions taken to resolve it.
21. A supplier must agree to furnish CMS (formerly HCFA) any information required by the Medicare statute and implementing regulations.