****

**CLIENT INFORMATION/SERVICE**

Business hours are Monday through Friday 8:30 a.m. – 5:00 p.m. The office phone number is 216-252-3900 or toll free 800-762-5438. After hours service is available by calling these numbers. A standard fee of $96 applies to after hours calls unless the call is an emergency (failure of life-sustaining equipment). There is no charge for emergency calls. Should a life threatening situation arise, it is suggested that the client or caregiver dial “911” for care.

**SAME OR SIMILAR EQUIPMENT**

If you have received similar equipment in the past – your insurer may not cover the item being requested for you. If you have any questions, please contact Health Aid of Ohio Customer Service at the phone number listed above.

**ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE**

I request that payment of authorized Medicare, Medicaid, or private insurance benefits be made to Health Aid of Ohio for any covered services furnished to me by Health Aid. I authorize any holder of medical information about me to release to CMS and its agents, or to any private insurance company and information needed to determine these benefits or the benefits payable to related service. I authorize release of my clinical records to Health Aid. These entities may also make copies of these records. I UNDERSTAND THAT I HAVE THE RIGHT TO REFUSE THE RELEASE OF MY RECORDS AND THAT I AM WAIVING THIS RIGHT BY SIGNING THIS CONSENT. I understand that I may revoke this consent by sending written notice to Health Aid. Such revocation shall have prospective effect only. I further authorize Health Aid to release this information to accrediting organizations for the purpose of compliance requirements. Additionally I authorize Health Aid to obtain and review my personal medical records that are held by other agencies for the purpose of submitting claims to my insurance.

**FINANCIAL AGREEMENT/PAYMENT AGREEMENT**

The financially responsible party agrees, that in consideration of the services to be rendered, that they guarantee and obligate themself to pay the account with Health Aid in full. They understand that Medicare, Medicaid and other insurers have guidelines (other than a physician’s prescription), that must be met to determine medical necessity in order to make payment. They understand Health Aid verifies the insurance policies presented to them upon accepting Health Aid as their Durable Medical Equipment Supplier. The information provided during an insurance verification is never a guarantee of benefits. The financially responsible party understands that they are ultimately responsible for knowing the insurance benefits. They hereby agree to pay any claim for goods or services not covered or denied for any reason by insurance since the date of delivery. They also understand that they are responsible for any co-pay or deductible amounts after claims are paid by said insurance. The responsible party agrees that if the rental or loaner equipment is lost, stolen or damaged, they will pay Health Aid for the cost of replacement or repair of the equipment. In addition, the responsible party agrees to be responsible for the full amount of the charges if no payment has been made by the insurer within 60 days from the date the claim was submitted to an insurance company or if the patient’s physician or responsible party fail to provide within 30 days the information necessary to submit the claim for services.

**RETURNS OF EQUIPMENT**

*Standard Equipment* may be returned within 30 days if unused and accompanied with a receipt. Unused bathroom equipment in the original packaging may be returned within 7 days when accompanied with a receipt. Health Aid will not accept returned merchandise if worn next to the skin, used for sanitary or hygienic purposes or if it is disposable.

*Custom equipment – A deposit of 50% is required upon the order of custom items. Custom items may not be returned.* I understand that the device or equipment being ordered on my behalf is considered custom-made and that it can’t be returned. I agree to accept responsibility for the payment of such fees if the device is unable to be delivered due to my death, cancellation of the order by me, or change in my condition such that the device is no longer medically necessary or appropriate. ***Compression stockings, braces, lift chair, breast pumps, custom wheelchairs and accessibility product sales are final and these items are not returnable. No exceptions will be made.***

**CLIENT COMMUNICATIONS, PERCEPTION OF CARE AND COMPLAINT/GRIEVANCE PROCESS**

In the event of a concern, question or complaint regarding care, the client should contact Health Aid of Ohio. Regardless of any complaint, prescribed/medically necessary services shall continue as ordered without fear of reprisal and without interruption. Complaints that can’t be quickly resolved via the telephone will be forwarded to the appropriate department manager and addressed within 5 calendar days.

Should you feel that your issues are not being adequately addressed, you are urged to contact the following entities:

Administer Federal 877-299-7900

State Attorney General/Ohio AG Cares 800-282-0515

Ohio Board of Pharmacy 614-466-4143

JCAHO 630-792-5636