HOME MEDICAL EQUIPMENT

Terms and Agreements

Customer Copy

Rev Feb 15, 2020

Freedom Mobility Center LLC
586 Parker Avenue, Rodeo, CA 94572
Tel: 510-799-9920 ● Fax: 510-799-9930
info@freedomhem.com ● www.freedomhme.com
Regular Business Hours 9am-5pm M-F

After Hours Answering Service: 5pm & 9am M-F (Weekends)
Calls Made After Hours Will Be Returned Within 48 Business Hours

Freedom Mobility Center LLC
Terms and Agreements

Thank you for choosing Freedom Mobility Center (FMC) as your Home Medical Equipment provider. FMC is a Family Owned and Operated *Durable Medical Equipment Company*. Our goal is to make sure you are completely satisfied with your purchase. Please feel free to contact us anytime you have questions about your equipment.

This document packet includes information, notices, and documents that we must give you to comply with Medicare, Medi-Cal, Private Insurance Companies, Health Plans, and Federal & State Laws during your evaluation, delivery, and setup:

Notices:
- HIPAA Privacy Notice
- Patient Rights and Responsibilities Notice
- 30 Supplier Standards Notice
- Our Warranty, Return, and Complaint Policies
- Return Check and Electronic Funds Transfer Policy

Customer Copies (*if applicable***):**
- Assignment of Benefits (if paying with insurance)
- Release Medical History (if paying with insurance)
- Option to Rent or Purchase (if paying with Medicare)
- Advanced Beneficiary Notice (if not covered by Medicare)
- Equipment Training & Safety Checklists
- Rental Agreement (if Renting equipment)
- Repair Consent Form (if we are Repairing your equipment)
- Loaner Warning/Agreement (if renting a Loaner Wheelchair)
- Home Outlet Electrical Waiver

HIPAA PRIVACY NOTICE

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), established a "Privacy Rule" to help ensure that personal health care information is protected for privacy. This notice describes how medical information about you may be used and disclosed and how you can get access to this information. FMC believes the information we gather about you is very private and we are dedicated to keeping this information confidential. The records we create are kept confidential by law. The following policy pertains to the use and storage of your personal health information:

Privacy Policy & Your Privacy Rights:
- We may collect and share appropriate information about you to document the medical necessity of the equipment, supplies or services we are providing. Examples include diagnosis, prescription, and physician or health care provider information.
- We may share appropriate information about you, including insurance coverage and eligibility verification, with your doctor, insurance, and family members you have informed us of, in order to bill and collect payment for equipment and services
- We may use and disclose information to monitor and operate our business as required by law. Examples include satisfaction surveys, health care outcomes and utilization reporting, accreditation bodies, and reports provided to any federal, state or local authority, or to remind you of equipment, supplies or service needs.
- We may release appropriate information about you to family or friends that are helping you with the financial responsibilities incurred for equipment, supplies or services from us.
- We may use and disclose information about you to respond to a court or authority that legally requests information about you.
- You have the right to refuse the sharing and use of your personal health information, and you have the right to direct the use of your personal health information.
- If you choose to give your consent, you have the right to revoke or change all or part of your personal health information at a later time, however, you may not revoke actions that have already been taken that relied on previously signed consent.
- You have the right to terminate or revise your authorization to our use of your personal health information, and have those terminations or revisions affect any new equipment, supply, or service provisions. We will honor your specifications, except where prohibited by law. All requests must be in written form.
- You have the right to request a copy of your personal health information as long as any federal, state or local law does not prohibit it. This request must be in writing. There may be a charge for copying, producing and delivering your information.
- You have the right to request, in writing, a revision to your personal health information. At no time will a revision be made that may erroneously record the personal health information stored by us. Your written request must detail the requested revision and the reasons for the modification. If no explanation is provided, no revision will be made.
- You have the right to request an accounting of non-routine disclosures we have made with your personal health information.
- You have the right to file a complaint about our use of your personal health information with us or the Secretary of the Department of Health and Human Services.

PATIENT RIGHTS & RESPONSIBILITES NOTICE

Patient Rights: As an individual receiving home medical equipment and services, let it be known that you have the following rights:
- To select those who provide your home care services.
- To be provided with legitimate identification by any person or persons who enter your residence to provide home care services for you.
- To receive the appropriate or prescribed service in a professional manner without discrimination relative to your age, race, sex, religion, ethnic origin, sexual preference or physical/mental disability.
- To be dealt with and treated with friendliness, courtesy and respect by each and every individual representing the company who provides treatment or services for you
- To assist in the development and planning of your home care program so that it is designed to satisfy, as best as possible to your current needs.
- To be provided with adequate information from which you can give your informed consent for the commencement of service, the continuation of service, the transfer of service to another home care provider, or the termination of service.

- To express concerns or grievances or recommend modifications to your home care services without fear of discrimination or reprisal. The Medicare hotline number is 1-866-238-9650.
- To request and receive complete and up-to-date information relative to your condition, treatment, alternative treatments and risks of treatment.
- To receive treatment and services within the scope of your home care plan, promptly and professionally, while being fully informed as to company policies, procedures and charges.
- To refuse treatment and services within the boundaries set by law, and to receive professional information relative to the consequences that will or may result due to such refusal.
- To request and receive the opportunity to examine or review your medical records

Patient Responsibilities: As an individual receiving home care services you have the following responsibilities:

- To provide accurate and complete information and notify FMC of any changes in status, including medical condition, or change of address or insurance.
- To advise FMC of any changes in phone number, address, physician, insurance company or payer source.
- To comply with Physician's prescribed treatment and be responsible for the outcomes if you do not follow the prescribed treatment.
- To make known whether you understand the products and services provided and what you are expected to do.
- To comply with the service plan and to communicate any change in the physician's order.
- To plan for any emergencies that may occur in the home.
- To respect the rights, professional integrity and dignity of those providing your care.
- To notify our staff if you wish to cancel services or change a scheduled visit.
- To follow instructions, rules, and regulations provided by FMC.
- To properly store, clean and maintain your equipment as recommended by FMC and the manufacturer.
- To contact FMC when equipment is not working properly and to allow FMC access to equipment for repair and maintenance.
- To meet the financial obligations agreed to with FMC.

30 SUPPLIER STANDARDS NOTICE

The products and/or services provided to you by Freedom Mobility Center LLC are subject to the supplier standards contained in the Federal regulations shown at 42 Code of Federal Regulations Section 424.57(c). These standards concern business professional and operational matters (e.g. honoring warranties and hours of operation). The full text of these standards can be obtained at http://www.ecfr.gov. Upon request we will furnish you a written copy of the standards.

WARRANTY POLICY

Manufacturer Warranty: FMC will honor all Manufacturer Warranties. Most Power Wheelchairs come with a One Year Manufacturer's Warranty (batteries 6 months). FMC will provide you with an Owner's Manual and the Manufacturer's Warranty details for all durable medical equipment.

Repairs During Warranty: All equipment will be repaired or replaced during the warranty period. Repairs will be performed by the Manufacturer, or a Certified and Accredited Independent Contractor, or by FMC as deemed necessary and appropriate.
Repairs End Of Warranty: FMC also offers repair service for equipment that is out of warranty. Parts and hourly labor rates will be based on the allowable amounts set by your insurance. FMC accepts assignment for Parts and Labor and will submit claims to your insurance appropriately.

RETURN & EXCHANGE POLICY

Special Orders: All products and equipment that are custom manufactured, custom-made, or are not regularly stocked, are NON-REFUNDABLE, NON-EXCHANGEABLE, and CANNOT BE CANCELLED once the order is placed due to the custom *made-to-order* processes involved, however, if a special order item arrives damaged, defective, or there is an error in the configuration or design due to manufacturer error, rest assured your item will be modified or replaced at no charge to you. All damage, defects, and configuration errors must be reported within "3 Calendar Days" after the delivery date.

Note: For billing purposes, the *"Date of Service"* for **Special Orders** is the date the order is *"Placed in Motion"*, which could be the *"Insurance Auth Date", "Order Date", "Delivery Date"*, or *"Storage Date"* depending on the specific product or equipment.

For all other product returns, refunds, and exchanges, FMC must be notified within "3 Calendar Days" after the delivery date if the item was sub-standard, less than full quality, unsuitable, or inappropriate for the beneficiary. We ask for your cooperation that all products be returned in their original packaging in like-new original condition with all of the original documentation included (*for health concerns, some bath safety products and personal use items are non-returnable*). For exchanges, please keep in mind your insurance provider may not pay for more expensive or upgraded items unless medically necessary.

COMPLAINT POLICY

FMC strives to meet the needs of every customer by providing the very best products, equipment, and services available. However, if you feel that we do not measure up in any way, you have the right to freely voice grievances and recommend changes in care or services without fear of reprisal or unreasonable interruption of services. Complaints will be communicated to management and documented in your file. The complaint will include your name, address, telephone number, and health insurance claim number, a summary of the complaint, the date it was received, the name of the person receiving the complaint, and a summary of actions taken to resolve the complaint. All complaints will be handled in a professional manner. All logged complaints will be investigated, acted upon, and responded to in writing or by telephone within a reasonable amount of time after the receipt of the complaint. If there is no satisfactory resolution of the complaint, the next level of management will be notified progressively up to the president or owner of the company. To file a complaint with FMC you may contact our compliance officer by regular mail, email, or by fax.

Attn: Compliance Officer,
Freedom Mobility Center LLC,
586 Parker Avenue Rodeo, California 94572 USA
Fax: 510.280.7271 email: complaints@freedomhme.com

STORAGE & DISPOSAL OF CUSTOMER EQUIPMENT
As a courtesy, FMC will hold customer's equipment/parts in storage free of charge for 3 months if the customer cannot take possession or delivery due to circumstance beyond their control (i.e. illness, hospitalization, natural disaster, etc). After 90 days of free storage, FMC will charge a storage fee of $50 per month for customer equipment/parts stored in our facility. FMC will bill the customer monthly for the storage fee until the customer makes arrangements for delivery or removal of the equipment/parts. If the customer does not take delivery or remove the equipment/parts within 6 months, FMC reserves the right to properly dispose or donate the equipment/parts.

RETURN CHECK FEES AND EFT POLICY
You will be charged a $20 fee for return checks and stop payments. When you provide a check as payment, you authorize us to use information from your check to make a one-time Electronic Funds Transfer (EFT) from your account and process the payment as a check transaction, or use a bank draft. When we use information from your check to make an EFT, funds may be withdrawn from your account the same day you make your payment. If your payment is returned unpaid due to Insufficient Funds or a Stop Payment initiated by you, you authorize us to collect a service charge, via a one-time EFT or using a bank draft drawn on your account, of $20 for each Return Check and/or Stop Payment.

ASSIGNMENT OF BENEFITS *(If Paying with Insurance)*
Medicare, Medi-Cal, and Private Insurance decide what a reasonable payment is for all medical supplies, equipment, and services. This payment is called the "Allowable Price." When a supplier like FMC agrees to accept the Allowable Price, the supplier is "Accepting Assignment", which means we must submit your claim to Medicare, Medi-Cal, or your Private Insurance directly on your behalf. We cannot charge you for submitting the claim, and we cannot charge you more than the Allowable Price. Payments are made directly to FMC by Medicare, Medi-Cal, or your Private Insurance.

Agreement To Pay / Financial Responsibility: If you change your insurance after receiving equipment, it may cause a denied payment to FMC, and you will be responsible for payment. Assignment of Benefits does not guarantee FMC will be paid by your insurance.

Since FMC must provide services and equipment to you "before" submitting claims to your insurance for payment, you should not sell, give-away, or discard your equipment until FMC has received the full payment from your insurance.

If your insurance denies payment to FMC you will be responsible for returning the equipment in like-new condition, or you can choose to purchase the item at the Allowable amount. All insurance eligibility verifications of coverage are based on plan provisions, and are not a guarantee of benefits. FMC will submit your claim, but it remains your responsibility to make sure the claim is paid. We strongly recommend that you contact your insurance company to discuss your coverage.

Patient Attestation*: I authorize direct payment from my insurance to FMC for authorized services/equipment furnished to me by FMC. In the event payments for insurance benefits are made directly to me on an assigned claim, I will endorse all checks for such payments or otherwise reimburse FMC the amount due.*

While insurance or other coverage may exist for the Equipment provided to me by FMC, I understand that not all Equipment may be covered, or that reimbursement may be less than 100% of billed charges in accordance with my coverage. Therefore, I agree to be financially responsible for any balance owed on my account including co-payments, coinsurance and deductibles, or even the full amount if the insurance company denies or recoups payment for services/equipment originally thought to be covered. I understand that if I fail to notify FMC immediately of a change in insurance carrier, and charges are not paid by the new carrier for any reason, I will be financially responsible for the full amount not paid. Outstanding charges are due within 15 days from date of billing statement. I understand that if I do not pay for this product or service upon receipt of an invoice, I may receive phone calls from or on behalf of Freedom Mobility Center LLC. I consent to receiving future auto-dialed calls, pre-recorded calls, or both, and understand that my consent to such calls is not a condition of purchasing any goods or services. Unpaid accounts will be sent to collections, with collection costs charged to the patient/legal agent.

RELEASE MEDICAL HISTORY *(If Paying with Insurance)*
Your Authorization to Release Medical Information will be used to determine medical necessity, benefits payable, and to submit claims and collect payments for products or services ordered and/or provided by FMC. A copy of this authorization will be sent to your insurance provider or doctor if requested by them. The original authorization will be kept on file by FMC (please see our HIPAA Notice of Privacy Practices).

Patient Attestation *I hereby authorize the release of all medical information necessary for determining medical necessity, and for processing insurance claims on my behalf. I understand that I am under the control of my physician and that FMC is not liable for any act or omission when following the instructions of said physician. I authorize FMC to contact me via mail, email or phone to inform me of special programs/sales related to or a logical adjunct of the products I have received.*

I further authorize the release/disclosure of my Protected Health Information (PHI) and any records pertaining to my medical history for products or services rendered, to be reviewed by FMC, my insurance, or other healthcare entities/providers involved in my care for purposes of determining benefits, processing a claim for payment, performance improvement, accreditation, certification, licensing or if required by federal, state or local law. FMC may disclose my PHI to family or friends involved in my care, unless I refuse in writing. (See our Privacy Notice for full list of disclosures.)

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE
(If item is not covered by Medicare)

A. Notifier: Freedom Mobility Center LLC 586 Parker Ave, Rodeo, CA 94572 T 510-799-9920	**B. Patient Name:**	**C. Patient ID:**

Note: Medicare does not pay for everything, even care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the Items listed in "**D**" below. If Medicare does not pay for the Items listed in "**D**" below, then you may have to pay:

D. Equipment\Service:	**E. Reason Medicare Might Not Pay:**	**F. Estimated Cost:**

What You Need To Do Now: 1) Read this notice, so you can make an informed decision about your care; 2) Ask us any questions that you may have after you finish reading; 3) Choose an option below about whether to receive the Equipment or Service listed above. Note: If you choose Option 1 or 2 below, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. Options: Check only one box. We cannot choose a box for you.

[__] OPTION 1. I want the D. Item listed above. FMC may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, FMC will refund any payments I made to FMC, less co-pays or deductibles

[__] OPTION 2. I want the D. Item listed above, but do not bill Medicare. FMC may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

[__] OPTION 3. I don't want the D. Item listed above. I understand with this choice I am not responsible for payment, and I can't appeal to see if Medicare would pay.

Additional Information This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE(1-800-633-4227/TTY: 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

Signature:	**Date:**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer Baltimore, Maryland 21244-1850

Form CMS-R-131 (03/11) Form Approved OMB No. 0938-0566

OPTION TO RENT OR PURCHASE *(If Paying with Medicare)*
Medicare Capped Rental and Inexpensive or Routinely Purchased Items Notifications for Services on or after 1/1/2006

Capped Rental Items: (not eligible under Medicare for outright purchase) Medicare will pay a monthly rental fee for a period not to exceed 13 months after which ownership of the equipment is transferred to the Medicare beneficiary. After ownership of the equipment is transferred to the beneficiary; it is the beneficiary's responsibility to arrange for any required equipment service or repair. These items will be identified as a rental item on your delivery ticket. These items include (but are not limited to):

- Basic Manual Wheelchairs, Tilt in Space, Pediatric Manual Wheelchairs, Standard Power Wheelchairs, and the accessories\replacement parts such as: Vent Trays, Electronics, Joysticks, and Power Assist Wheels.
- Hospital Beds, Alternating Pressure Pads, Air-fluidized Beds, Patient Lifts, and Trapeze bars.
- Nebulizers, Suctions Pumps, CPAP, and BIPAP Devices.

Inexpensive or Routinely Purchased Items: Equipment in this category can be purchased or rented; however, the total amount paid for monthly rentals cannot exceed the fee schedule purchase amount. These items include (but are not limited to):

- Canes, Walkers, Crutches, Commodes.
- Low Pressure and Position Equalizing Pads.
- Blood Glucose Monitors and Pneumatic Compressors (Lymphedema-Pumps).
- Bed Side Rails and Seat Lift Mechanisms.
- Complex Power Wheelchairs and Custom Manual Wheelchairs.
- Complex Powered Wheelchair Seating items, accessories such as Vent Tray, Electronics, Joystick Controllers, and Power Wheelchair repair service and replacement parts.

Patient Attestation*: I received instructions and understand that Medicare defines items that I received as being either a capped rental item, or an inexpensive / routinely purchased item as defined above. I understand some items on my Delivery Ticket may be rented or purchased, and I have been given an option to Purchase or Rent those items at time of delivery.*

TRAINING & SAFETY CHECKLIST
General Checklist

- Ensure that the appropriate person(s), in addition to the patient, are present during instruction.
- Ensure a return demonstration was performed by patient\caregiver and no questions\problems were present.
- Advise that no one should attempt to repair the equipment.
- Provide an on-call phone number and contact information to patient\ caregiver, and explain the company service policy, after hours response, equipment malfunction, etc.
- Provide an Instruction Booklet, Owners Manual, and/or Warranty Information to patient\caregiver, if applicable.
- Instruct patient\caregiver to follow all infection control procedures included in the manufacturer's instruction booklet\owner's manual, to include, but not be limited to appropriate cleaning\disinfection procedures.
- Explain the weight limit for the equipment based on the manufacturer's owners manual and model.
- Provide instructions and explain the following topics to patient\caregiver for the applicable equipment:

Air Cushion Checklist (Seat):

- Demonstrate proper inflation with user sitting on the cushion.
- Slide hand between cushion and client's buttocks and Turn valve counter-clockwise to release air until you feel .5 to 1 inch of airspace between client and the seated surface. Turn valve clockwise to close valve
- To not sit on an improperly inflated cushion.
- Explain under inflation and over inflation of the cushion reduces or eliminates the cushion's benefits and could increase risk to the skin or other soft tissue.
- The cushion is most effective when there is .5 to 1 inch of air between the client's bottom and the seating surface
- On memory control and must be unlocked when transferring
- To check for proper inflation and adjust the cushion at least once a day.
- On cushion and cover orientation: product must be used with air cells facing up.
- If cover is not used correctly, or if the cover is the wrong size, it may reduce the benefits of the cushion.
- That changes in altitude my require adjustment to cushion.
- To keep cushion away from sharp objects, high heat, or open flame.
- To not place any obstructions between client and cushion as this will reduce the product effectiveness.

- To not allow any oil-based lotions or lanolins to come into contact with cushion.
- To wipe cushion with mild soap and water, and wash the cover on gentle cycle in washing machine. DO NOT use in dryer, hang and air dry

Air Mattress/Pad Checklist (Support Surface):

- How to turn on\off and position the pump and\or pad.
- DO NOT use in the presence of smoking materials or open flame. Air flowing through this pad will support combustion.
- Explain unit may be cleaned occasionally, dusting or wiping with a surface germicidal disinfectant solution. DO NOT immerse, heat, or steam.
- Replacement Alternating Pressure Pads available, if applicable.

Ambulatory Aids Checklist:

- On how to adjust height, and how to fold, if applicable.
- On brake operations, and attaching basket if applicable.
- To use caution when using outside in wet weather.
- To use mild soap and water or non-abrasive cleaner
- To inspect the rubber tips, handgrips, and\or under pads, if applicable and regularly replace worn or damaged parts immediately.

Bath Aids Checklist

- How to adjust equipment height.
- To be aware of removable parts, and inspect rubber feet or tips, and regularly replace worn or damaged tips immediately.
- To ensure that all shower\bath aids are air-dried between uses.
- To use mild soap and water or a non-abrasive cleaner for cleaning. NEVER use a water spot remover to clean equipment.
- To NOT install this equipment without first reading instructions.
- To use arm supports only for assistance (if applicable).
- Explain Assist bars are NOT grab bars. The suction cups will NOT support full load bearing. Use at your own risk.

Hospital Bed Checklist:

- To keep hands and feet clear of all moving parts.
- DO NOT allow children to operate, or be on or near bed during operation.
- To make sure Power supply cord, plug and grounding are all intact, and power cord does not interfere with moving parts.
- On operation of raising\lowering bed, head up\down, foot up\down, and wheels and wheel locks are operating properly.
- On the side rail function\operation.
- On the manual operation of the bed in case of power failure.

Patient Lift and Trapeze Checklist:

- How to adjust Trapeze bar height, hand grip triangle, and stand placement.
- How to check clamps and wing nuts monthly for proper position\tightness. Instructed patient\caregiver to not tighten wing nuts with pliers or other tools (hand tighten ONLY).
- How to operate patient lift with the base legs in maximum open position and unlock in place when lifting a patient for maximum stability.
- To be sure that the sling is secure and is properly attached before the patient is completely removed from the bed or chair.
- To be sure equipment is not used for transferring the patient from room to room.
- How to operate the equipment, hydraulic pump handle, patient lift, sling position, and proper lifting\lowering.

Reclining Lift Chair Checklist:

- On the safe use of the pendant control
- How to replace the 9V batteries.
- To watch for small pets and children underneath the equipment.

Wheelchair (Power) and Scooter Checklist:

- Always wear a seatbelt.
- DO NOT, without attendant, attempt to go up inclines steeper than 10% (1 foot of elevation for each 10 feet of ramp).
- To turn OFF power when transferring to\from chair.
- On safe operations, charger operations, and joystick functions.
- On moving/removing/adjusting arm rest, leg rest, and foot rest.
- On how to engage and disengage motors for locking and freewheel.
- On how to break down, if applicable.

Wheelchair (Manual) Checklist:

- How to secure wheel locks when transferring in\out of wheelchair.
- How to not shift weight in the direction you are reaching.
- How to not, without attendant, attempt to go up inclines steeper than 10% (1 foot of elevation for each 10 feet of ramp).
- Demonstrate potential hazards of equipment such as: Loss of balance on curbs\ramps with resultant backwards tipping, Rolling of chair out from under patient when failing to set locks, and Pinch points on chair.

FMC Technician Attestation: I attest the patient (or caregiver) demonstrated the knowledge and safe operation of the Equipment.

Patient / Caregiver Attestation: I attest that I have received and understand all of the information and documents as listed above. I have witnessed all safety checks performed by the service technician and I have been fully instructed on the use and operation of my equipment (Wheelchair, Bed, etc)

ELECTRICAL WAIVER CONSENT For your medical equipment to function properly your electrical outlets should be grounded properly. It is your responsibility to make sure your outlets are grounded to ensure the safe use of the equipment and protect your home from electrical hazards. By using your equipment in an improperly grounded outlet, you are releasing FMC of all liabilities associated with the use of the equipment. We recommend that you arrange with a qualified electrician to have your outlets grounded.

HOLD HARMLESS Home Medical Equipment is designated for patient use only and not to be shared with or used by any other persons. Home Medical Equipment and Mobility Equipment are designed and engineered for use by one person only. Additional weight or cargo is not allowed on equipment. Adding additional cargo of any kind will destabilize the balance of the equipment and affect performance such as turning, stopping, acceleration, battery

performance, and wear & tear. DO NOT load or pull any additional cargo or weights such as, but not limited to: *luggage, groceries, other persons, children, and/or pets.*

Client has been advised of the possible risks, hazards, and prohibited uses associated with Home Medical Equipment, including but not limited to failure of power and parts; and risk of allowing other persons, children, pets, or cargo to interact with medical equipment; and client agrees to indemnify and hold harmless FMC, their officers, agents, and/or employees from any and all liability, claims, and demands, related to any loss, damage, injury, or death, that may be sustained by the client or others, or any property belonging to the client or others, caused by client's use of Home Medical Equipment.

Acceptance of Risk: I understand there is a risk of injury from using Home Medical Equipment, including the potential for bodily injury, death, and property damage. I understand that accidents can occur while using Home Medical Equipment as a result of negligence or otherwise. I KNOWINGLY AND VOLUNTARILY ASSUME ALL SUCH RISKS, BOTH KNOWN AND UNKNOWN, EVEN IF ARISING FROM THE NEGLIGENCE OF THE RELEASEES OR OTHERS, and I assume full responsibility using any Home Medical Equipment provided by FMC.

Covenant Not to Sue: I, on behalf of myself, my family, heirs, assigns, personal representatives, and administrators hereby release, waive, forever discharge, and agree to NOT sue or proceed in any manner against FMC, it's officers, directors, officials, members, agents, and/or employees, from and for any and all liabilities, claims, demands, and/or losses related to any and all injuries, disabilities, deaths, or damage to any person or property, as a result of using any Home Medical Equipment provided by FMC.

RENTAL AGREEMENT *(If You Are Renting Equipment)*
Freedom Mobility Center (FMC) agrees to provide medical equipment, services and/or supplies to the client. In consideration for providing these services, the client accepts and agrees with the following:
Inspection and Acceptance: client accepts the products/services as described on the "Delivery Receipt/Ticket" and acknowledges that he/she has had an opportunity to inspect the equipment and finds it suitable for their needs and in good working condition and understands its proper use. The client further acknowledges his/her duty to inspect the equipment prior to use and to immediately notify FMC of any defects.
Ownership: Unless specified expressly during a sale, any rental products described on the "Delivery Receipt/Ticket" remain the property of FMC.
Replacement of Malfunctioning Equipment: If the equipment becomes unsafe or falls into disrepair as a result of normal use, patient agrees to stop using the equipment immediately and notify FMC, who will replace (or repair) the rental equipment with similar equipment in good working order, if available. FMC is not responsible for any incidental or consequential damages caused by delays or otherwise.
Warranties: FMC will notify client of manufacturer's warranties, and when applicable, all manufacturer's warranties will be honored.
Hold Harmless: Client has been advised of the possible risks and hazards associated with DME equipment, including but not limited to, failure of power and parts, and client agrees to indemnify and hold harmless FMC, their officers, agents, and/or employees from any and all liability, claims, and demands, related to any loss, damage, injury, or death, that may be sustained by the client or others, or any property belonging to the client or others, caused by client's use of rented DME equipment.
Prohibited Uses: Use of the rental equipment in the following circumstances is prohibited and constitutes a breach of this contract (or an automatic conversion to sale); a) Do Not Use for illegal purpose or in an illegal manner; b) Do Not Use when there is reason to suspect or believe the equipment is in bad repair or is unsafe; c) Do Not Use at any location other than the address listed on the face of the "Delivery Receipt/Ticket" (i.e.: for home use only); d) Do Not Use outside or for travel (for inside home use only); e) Do Not let others use the Equipment; f) Do Not exceed the weight limit of the chair; g) Do Not load or pull any additional cargo or weights such as, but not limited to: luggage, groceries, other persons, children, and/or pets.
Term: The term of this agreement shall be continuous beginning with the delivery of the products/services and shall continue until the return of the products with all rental payments made and all other obligations fulfilled.
Rental Payments: The rent for the equipment shall be on a monthly basis from the date of delivery, payable to FMC. FMC will make no refunds or reduction in charges for any unused portion of the rental period unless prior arrangements have been made.
Retail Rental Payments: The first month's payment must be made upon delivery of the equipment. FMC reserves the right to keep the renter's credit card information on file, however, the card will only be billed; if the rented equipment is returned with inexcusable damage; if subsequent rental payments are missed; or if the equipment is lost or purposefully withheld.
Return of Rental Equipment: It is the patient's responsibility to notify FMC immediately if/when medical necessity for rented DME equipment has ended. The right to possession is terminated by the expiration of the prescription period. Retention of equipment after this time, without a new prescription, constitutes a material breach of this contract. Any extension of this contract must be mutually agreed upon in writing. The patient further agrees to return rented goods during FMC's normal business hours upon termination of the prescription period. If not returned timely, the patient shall pay an additional charge assessed by FMC for each month retained beyond the expiration of the prescription period.
Damaged or Lost Equipment: Patient agrees to pay for any damage to or loss of the equipment, as an insurer, regardless of cause, except reasonable wear and tear, while the equipment is out of possession of FMC. Accrued rental charges cannot be applied against the purchase or cost of repair of damaged or lost goods. Equipment damaged beyond repair will be paid for at its fair market value when rented. The cost of repairs will be borne by the patient whether performed by FMC or, at FMC's option, by others.
Time of Payment: Accounts are due and payable at the time of delivery and on the anniversary date for every month thereafter. FMC retains the right to assess late fees for overdue accounts. The patient further agrees to pay all reasonable collections; attorney's and court fees and other expenses involved in the collection of charges or enforcement of FMC's right under this agreement.

Repossession: Upon failure to pay rent or other breach of this contract, FMC may terminate this contract and take possession of the goods from wherever they are and FMC and its agents shall not be liable for any claims for damage or trespass arising from the removal of the goods.

Patient Attestation*: I acknowledge receipt of equipment and/or supplies listed on the Delivery Receipt/Ticket. I request that payment of authorized Medicare, Medi-Cal, or other private insurance benefits be paid directly to FREEDOM MOBILITY CENTER LLC for any services furnished to me by FMC. I authorize any holder of my medical information to release to the Centers for Medicare and Medicaid Services and its agents, any information needed to determine these benefits or the benefits payable to related services*

=CUSTOMER COPY=

REPAIR CONSENT FORM *(If we are Repairing Your Equipment)*

Repair Consent: [__Yes __No] *By checking Yes, I hereby give Freedom Mobility Center (FMC) consent to perform diagnostics and repair my equipment. I understand that prior authorization from my insurance is required before parts are ordered and/or repairs can be completed.*

Equipment Release: [__Yes __No] *By checking Yes, I hereby release my equipment to FMC to perform diagnostics and repairs in-shop. FMC is authorized to hold my equipment until a prior authorization request is approved or denied by my insurance. I may elect to pick up my equipment from FMC at any time prior to insurance approval at my own expense.*

[NOTE: Due to health and safety regulations and to protect customers, drivers must prevent cross contamination in delivery vehicles. Therefore, drivers will NOT pick up any equipment that has obvious signs of bodily fluids, fecal matter, urine, or pests. The equipment owner must make arrangements to have the equipment reasonably cleaned and sanitized prior to pickup.]

Hold Harmless: *I understand FMC makes no guarantees or promises as to when, or if, my repair will be approved by my insurance. I understand that performing diagnostics and repairs is a very time consuming and complex process, and is subject to delays beyond the control of FMC such as, but not limited to: insurance processing times; severity and difficulty of repair; availability of parts from manufacturer; order processing lead times; FMC case-load; travel distance; freight carriers; holidays; and acts of nature. Therefore, I agree to hold harmless FMC for any delays associated with the completion of my repair and/or return of my equipment.*

LOANER WHEELCHAIR AGREEMENT: [__Yes __No] *By checking Yes, I hereby elect to RENT a "USED" wheelchair (Loaner) from FMC for Indoor Use Only, and I agree to sign a "**Waiver and Release Of Liability Form**".*

TITLE 22 NOTICE *(If paying for Repairs with Medi-Cal):*

As your Durable Medical Equipment (DME) provider, FMC is providing this notice to inform you of your responsibilities for DME equipment purchased for you by your insurance.

Repairs: Repairs to equipment may be covered by your insurance when necessary to make your equipment serviceable. However, it is your responsibility to properly care for and maintain your equipment to avoid unnecessary repairs. Normal wear and tear is expected; however, abuse and/or neglect of your DME equipment may result in your insurance denying payment for repairs.

Replacement: Replacement equipment must be pre-authorized by your insurance and may be covered in cases of loss, theft, or irreparable damage. A police or incident report must be available upon request. Irreparable damage refers to a specific accident or natural disaster (e.g., fire, flood) and does NOT refer to normal wear and tear. Cases suggesting malicious damage, culpable neglect, or wrongful disposition of equipment will likely be denied. Replacement may also be considered when there is a significant change in your medical condition, or after your equipment's reasonable useful lifetime has been reached (5 years for most DME) when determined by your insurance to be more cost effective to replace rather than repair.

Patient Attestation: *I acknowledge that I have read the Title 22 notice above and that in accordance with title 22, section 51321, I agree to be responsible for appropriate use and care of durable medical equipment purchased for my use by my insurance.*

Covenants: These "Terms and Agreements", together with Freedom Mobility Center LLC's "Client Agreement - Assignment of Benefits", represent the entire agreement between the parties and supersedes all prior oral and/or written agreements and representations. No provision of this agreement may be waived or modified, unless in writing and signed by FMC. I agree this agreement will be binding on my heirs, representatives and assignees. I certify that all patient information provided to FMC is true, complete and accurate. Note: a copy of this Agreement and Consent shall be considered the same as the original, and all authorizations will remain in effect until revoked in writing.

Patient Attestation: *I hereby certify that: I am the patient beneficiary, or am duly authorized to execute this Agreement and accept its terms on behalf of the patient; I have been given an opportunity to read this document, understand its terms and conditions, and have received a copy thereof. I have received, or been offered and declined, the Medicare Supplier Standards, Patient Rights & Responsibilities, Privacy Notice and Scope of Services. I consent to the release of my PHI as needed for the purposes of treatment, payment, legal requirements and healthcare operations.*

LOANER WHEELCHAIR for INDOOR USE ONLY!

WARNING!

NOT SAFE FOR OUTDOOR USE

LOANER WHEELCHAIR AGREEMENT
WAIVER AND RELEASE OF LIABILITY

I understand Freedom Mobility Center (FMC) will not dispense a Loaner Wheelchair or Exchange unless this document is read, initialed, and signed:

THERE ARE MANY RISKS AND DANGERS WITH USING A LOANER WHEELCHAIR

- DO NOT use at any location other than the address listed on the Delivery Ticket (for in-home use only), because Loaner Wheelchairs are NOT always Reliable. Many failures are undetectable and unpredictable even with routine maintenance and inspection.
- DO NOT use the Loaner Wheelchair OUTDOORS! If the loaner wheelchair fails - YOU can get stranded away from home in unsafe places, or in extreme weather conditions. However, you may travel to and from doctor appointments with the Loaner Wheelchair only if you are transported door-to-door by a Wheelchair Transportation Company, Medical Transportation Company, or a private vehicle appropriately fitted to transport wheelchairs.
- YOU MUST wear the safety seat belt during use.
- DO NOT use the Loaner Wheelchair if there is any reason to believe the Equipment is UNSAFE.
- DO NOT use for illegal purpose or in an illegal manner.
- DO NOT use outside or for travel (unless an exception has been expressly given in writing).
- DO NOT let others use the Equipment
- DO NOT exceed the weight limit of the chair (not for hauling cargo or overloading with luggage, groceries, children, pets, etc.
- DO NOT use while smoking tobacco or using other products that can cause an odor to remain on the equipment.

I understand a Loaner or Loaner Exchange will NOT be dispensed if one or more of the following conditions are observed:

- My own equipment cannot access or safely navigate my home, or my own equipment is not used inside the home.
- My own equipment is stored outside the home. This includes sheds, garages and other storage rooms, even if they can be locked.
- My own equipment and/or my home shows signs of pests.

My own equipment shows signs of abuse or gross neglect, such as damage from nonstandard or unsafe use or exposing the equipment to destructive elements.

Must Initial Each Section

_____**1. Indoor Use Only:** I understand I do NOT have permission to use the Loaner outdoors. I agree to use the Loaner indoors only unless being transported door-to-door by a Wheelchair Transportation Company or a private vehicle appropriately fitted to transport wheelchairs for doctor appointments ONLY.

_____**2. Acceptance of Risk**: I understand there is a risk of injury from using a wheelchair, including the potential for bodily injury, death, and property damage. I understand that accidents can occur while using the Loaner wheelchair as a result of negligence or otherwise. I KNOWINGLY AND VOLUNTARILY ASSUME ALL SUCH RISKS, BOTH KNOWN AND UNKNOWN, EVEN IF ARISING FROM THE NEGLIGENCE OF THE RELEASEES OR OTHERS, and I assume full responsibility for the use of this Loaner wheelchair.

_____**3. Covenant Not to Sue**: I, on behalf of myself, my family, heirs, assigns, personal representatives, and administrators hereby release, waive, forever discharge, and agree to NOT sue or proceed in any manner against FMC, it's officers, directors, officials, members, agents, and/or employees, from and for any and all liabilities, claims, demands, and/or losses related to any and all injuries, disabilities, deaths, or damage to any person or property, as a result of using the Loaner Wheelchair.

_____**4. My Responsibilities**: I understand that if the Loaner is lost or stolen while in my possession due to neglect (i.e., left unattended outside the home, or kept in unsafe storage); or if I return my Loaner worn and/or damaged beyond what can be reasonably expected from standard use; FMC will not dispense a replacement Loaner, and I will be sent an invoice for the cost of the equipment or the damages. If I refuse to pay for loss or damages of the equipment, I understand that I will NOT be eligible for another Loaner on any future service calls.

_____**5. Availability**: I understand Loaner selection (make & model) is based on first-come first-serve fleet availability; and that an exact duplicate of my own wheelchair make & model will usually not be available.

_____**6. Signature**: I understand a new Waiver must be signed and dated by me for each loaner event, even if a previous signed copy is already on file.

I certify that I have read the agreement above and I understand the RISK and DANGERS of using a Loaner Wheelchair. I understand and agree the Loaner Wheelchair is for indoor use only. I will not use the Wheelchair outside and agree to abide by the terms of this agreement as listed above. I am aware that this is a Waiver and Release of Liability and I sign it of my own free will:

_____ _____

Customer (or Caregiver & Relationship) *Date*