OJMEDTECH

Dear New Patient,

Welcome and thank you for choosing OJ Medtech for your home healthcare medical supply needs! Enclosed in this packet you will find the following documents:

*** PLEASE NOTE - THESE TWO DOCUMENTS NOTED BELOW *MUST* BE COMPLETED, SIGNED AND RETURNED TO OJ MEDTECH – THEY ARE THE LAST 2 PAGES OF THIS DOCUMENT**

1. *Patient Acknowledgement of Documentation Receipt and Assignment of Benefits Statement
2. *Notice of Privacy Practices Acknowledgment Form

Please complete and return these two documents and return them as soon as possible to us, and ***Please note that these forms need to be on file with our office before we can deliver your supplies.***

PLEASE RETAIN THE REMAINING DOCUMENTS FOR YOUR RECORDS:

- DMEPOS Medicare Supplier Standards (for Medicare Beneficiary's only)
- Notice of Privacy Practices
- Patient Complaint/Grievances Policy
- Patient's Rights and Responsibilities
- Patient Agreement
- Billing and Reimbursement Practices

In the future, if there are any changes to your contact information, address, insurance or doctors, *please update us immediately so as to help that there are no breaks in our ability to provide you with services*.

We pride ourselves on our outstanding customer service, products and deliveries. Please contact us with any questions or comments about your supply needs or service.

Thank you for choosing OJ Medtech. We look forward to working with you!

Sincerely,
OJ Medtech
1973 Union Boulevard
Bay Shore, NY 11706
Toll Free: 888.414.9737 or 631-666-5000
www.ojmedtech.com

MEDICARE DMEPOS SUPPLIER STANDARDS

Note: This is an abbreviated version of the supplier standards 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. 424.57(c).

1. A SUPPLIER MUST BE IN COMPLIANCE WITH ALL APPLICABLE FEDERAL AND STATE LICENSURE AND REGULATORY REQUIREMENTS AND CANNOT CONTRACT WITH AN INDIVIDUAL OR ENTITY TO PROVIDE LICENSED SERVICES.
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. THIS STANDARD REQUIRES THAT THE LOCATION IS ACCESSIBLE TO THE PUBLIC AND STAFFED DURING POSTED HOURS OF BUSINESS. THE LOCATION MUST BE AT LEAST 200 SQUARE FEET AND CONTAIN SPACE FOR STORING RECORDS.
8. A SUPPLIER MUST PERMIT CMS, 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, ANSWERING SERVICE OR CELL PHONE DURING POSTED BUSINESS HOURS 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 CONTACTING A MEDICARE BENEFICIARY BASED ON A PHYSICIAN'S ORAL ORDER UNLESS AN EXCEPTION APPLIES.
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 ANY INFORMATION REQUIRED BY THE MEDICARE STATUTE AND IMPLEMENTING REGULATIONS.
22. ALL SUPPLIERS MUST BE ACCREDITED BY A CMS-APPROVED ACCREDITATION ORGANIZATION IN ORDER TO RECEIVE AND RETAIN A SUPPLIER BILLING NUMBER. THE ACCREDITATION MUST INDICATE THE SPECIFIC PRODUCTS AND SERVICES, FOR WHICH THE SUPPLIER IS ACCREDITED IN ORDER FOR THE SUPPLIER TO RECEIVE PAYMENT OF THOSE SPECIFIC PRODUCTS AND SERVICES (EXCEPT FOR CERTAIN EXEMPT PHARMACEUTICALS). *IMPLEMENTATION DATE - OCTOBER 1, 2009*
23. ALL SUPPLIERS MUST NOTIFY THEIR ACCREDITATION ORGANIZATION WHEN A NEW DMEPOS LOCATION IS OPENED.
24. ALL SUPPLIER LOCATIONS, WHETHER OWNED OR SUBCONTRACTED, MUST MEET THE DMEPOS QUALITY STANDARDS AND BE SEPARATELY ACCREDITED IN ORDER TO BILL MEDICARE.
25. ALL SUPPLIERS MUST DISCLOSE UPON ENROLLMENT ALL PRODUCTS AND SERVICES, INCLUDING THE ADDITION OF NEW PRODUCT LINES FOR WHICH THEY ARE SEEKING ACCREDITATION.
26. MUST MEET THE SURETY BOND REQUIREMENTS SPECIFIED IN 42 C.F.R. 424.57(C). *IMPLEMENTATION DATE- MAY 4, 2009*
27. A SUPPLIER MUST OBTAIN OXYGEN FROM A STATE- LICENSED OXYGEN SUPPLIER.
28. A SUPPLIER MUST MAINTAIN ORDERING AND REFERRING DOCUMENTATION CONSISTENT WITH PROVISIONS FOUND IN 42 C.F.R. 424.516(F).
29. DMEPOS SUPPLIERS ARE PROHIBITED FROM SHARING A PRACTICE LOCATION WITH CERTAIN OTHER MEDICARE PROVIDERS AND SUPPLIERS.
30. DMEPOS SUPPLIERS MUST REMAIN OPEN TO THE PUBLIC FOR A MINIMUM OF 30 HOURS PER WEEK WITH CERTAIN EXCEPTIONS

PATIENT COMPLAINTS/GRIEVANCES POLICY

Patients/clients and caregivers have the right to have all complaints heard, investigated and whenever possible, resolved. OJ Medtech promotes open communication between patients/parents/guardians and staff. The Company respects both the patients' rights and the need for effective communication.

Patients/clients are free to voice complaints or grievances regarding policies or services and recommend changes without coercion, discrimination, reprisal or unreasonable interruption of services. The complaint process includes intake, investigation, corrective action as applicable, complaint resolution, and follow-up. Patients receive required documentation about the Company's complaint-resolution process within their intake documentation.

OJ Medtech receives, investigates and responds to complaints and recommendations received from patients/clients. Upon admission, OJ Medtech provides oral and/or written notification of its complaint-resolution process and other resources for registering complaints. The patient's/customer's record must document all communication, signed and dated by a staff member.

A patient/client may file a complaint or grievance by calling customer service at 888-414-9737. The complaint may also be submitted in writing to the Company CEO, Peter Tallas at 33 Riverside Drive, Suite 200 Pembroke, MA 02359.

The complainant will be notified within 5 business days of receipt that the complaint has been received and is being investigated. The Company will initiate an investigation by interviewing staff involved, reviewing delivery van logs if applicable, checking patient's file including delivery slips and other documentations. If necessary, the patient and/or caregiver will be contacted for more information. If collateral sources are to be contacted for information, the patient will be notified and information release forms will be obtained.

Within 14 business days, a written response of the outcome of such investigation for the complaint resolution will be sent to the patient.

A complete report of the initial complaint and subsequent investigation and resolution is to be kept by the Compliance Manager in a secure file, and a summary is documented in the patient's file.

Patients may call our accrediting organization, BOC, to file a complaint or question about OJ Medtech as an organization if deemed necessary. BOC Hotline: 877-776-2200 (9-5pm Monday-Friday eastern standard time).

Patients may also call their own health insurance plan or Medicare at 1-800-633-4227 to register a complaint, if deemed necessary.

OJMEDTECH

NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Promulgated Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

EFFECTIVE SEPTEMBER 18, 2013
THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR PROTECTED HEALTH INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

The terms of this notice apply to all records containing your protected health information that are created, received, maintained or transmitted by our Company, our Business Associates and their subcontractors. We reserve the right to revise and amend our notice of privacy practices. Any revision or amendment to this notice will be effective for all of your records our company has created or maintained in the past, and for any of your records we may create, receive, maintain or transmit in the future. Our Company will post a copy of our most current notice in our offices in a prominent location and on our website. You may request a copy of our most current notice by telephone, in writing or by e-mail.

B. IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

By Phone: 888-414-9737 or write to: Peter Tallas - CEO, 33 Riverside Drive Suite 200, Pembroke, MA 02359.

C. WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION IN THE FOLLOWING WAYS

The following categories describe different ways in which we may use and disclose your identifiable health information. Except for the purposes described below, any other uses or disclosures of protected health information not covered by this notice to include for the purposes of marketing or disclosures that would constitute a sale of your protected health information and or the laws that govern us will only be made with your written authorization.

1. Treatment. Our company may use and disclose your protected health information for your treatment and to provide you with treatment related services. For example, we may disclose health information to doctors, nurses, or other personnel, including people outside our office / company, who are involved in your medical care and need the information to provide you with medical care.

2. Payment. Our company may use and disclose your protected health information in order to bill and collect payment for the services and items you receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits and we may provide your insurer with details regarding your services and home healthcare items to determine if your insurer will cover, or pay for, these services and items. We also may use and disclose your protected health information to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your protected health information to bill you directly for services and items not covered by health insurance.

3. Health Care Operations. Our company may use and disclose your protected health information to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our company may use your health information to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our company.

4. Business Associates. Business Associates are parties with which we conduct business in order to provide you with our services which include but are not limited to provisions of medical equipment and its assembly, medical supplies, home delivery service of equipment and supplies, and medical billing to your health insurance payer, yourself or other designated parties. Our company may use and disclose your protected health information to Business Associates. Business Associates will be provided only with the minimum of health information necessary in order for them to perform the activities of their business that they conduct on our behalf.

5. Appointment Reminders. Our company may use and disclose your protected health information to contact and remind you of visits/deliveries.

6. Health-Related Benefits and Services. Our company may use and disclose your protected health information to inform you of health-related benefits or services that may be of interest to you.

7. Release of Information to Family/Friends. Our company may release your protected health information to your family, a relative, a close friend or any other person you identify as involved in helping you pay for your health care, or who assists in taking care of you, unless you object. Please see "YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION" section of this Notice of Privacy Practices for further information.

8. Disclosures required by law. Our company will use and disclose your protected health information when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR IDENTIFIABLE HEALTH INFORMATION IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we or our Business Associates (only if or when applicable) may use or disclose your protected health information:

1. Public Health Risks. Our company may disclose your protected health information to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records such as births and death
- Reporting child abuse or neglect
- Preventing or controlling disease, injury or disability
- Notifying a person regarding potential risk for spreading or contracting a disease or condition
- Reporting problems with products or devices
- Notifying individuals if a product or device they may be using has been recalled
- Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); we will only disclose this information if the patient agrees or we are required or authorized by law to disclose information.

2. Health Oversight Activities. Our organization may disclose your protected health information to a health agency for activities authorized by law. Oversight activities can include for example, investigations, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care systems in general.

3. Lawsuits and Similar Proceedings. Our organization may use and disclose your protected health information in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your protected health information in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you or to obtain an order protecting the information the party has requested.

4. Law Enforcement. We may release protected health information if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe might have resulted from criminal contact
- Regarding criminal contact at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime including the location(s) or victim(s) of the crime, or the description(s), identity(ies) or location(s) of the perpetrator(s).

5. Serious Threats to Health or Safety. Our organization may use and disclose your protected health information when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to prevent the threat.

6. Military. Our organization may disclose your protected health information if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate military command authorities.

7. National Security. Our organization may disclose your protected health information to federal officials for the intelligence and national security activities authorized by law. We also may disclose your protected health information to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

8. Workers' Compensation. Our organization may release your protected health information for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

You have the following rights regarding the protected health information that we maintain about you:

1. Inspection and Copies. You have the right to inspect and obtain a copy of protected health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to: **Peter Tallas – CEO; 33 Riverside Drive Suite 200, Pembroke, MA 02359**, in order to inspect and/or obtain a copy of your protected health information. Our organization may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our company may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Reviews will be conducted by another licensed health care professional chosen by us.

2. Electronic Copy of Electronic Medical Records. If your protected health information is maintained in an electronic format (that is, a digital electronic medical or health record), you have the right to request that an electronic copy of your record be sent or transmitted to you or to another individual or entity. Presently our organization doesn't utilize an electronic medical or health record format. However,

if we at some point implement use of an electronic medical / health record format you will be eligible to request your heath records in this format.

3. Right to Request Protected Health Information be Sent to Directly to Another Individual / Third Party. If you wish to have your protected health information sent to a third party your request must be made in writing and submitted to: **Peter Tallas – CEO; 33 Riverside Drive, Suite 200 Pembroke, MA 02359**. Your request must clarify the identity of the persons designated to receive this information and the address to which copies must be sent.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment as long as the information is kept by or for our organization. To request an amendment, your request must be made in writing and submitted to: **Peter Tallas – CEO; 33 Riverside Drive Suite 200, Pembroke, MA 02359**. You must provide us with reasons that support your request for amendment. Our organization will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is: (a) accurate and complete; (b) not part of the identifiable health information kept by or for the organization; (c) not part of the identifiable health information which you would be permitted to inspect and copy; or (d) not created by our organization, unless the individual or entity that created the information is not available to amend the information.

5. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your identifiable health information for payment or health care operations. Additionally, you have the right to request that we limit our disclosure of your protected health information to individuals involved in your care or payment for your care, such as family members and friends. **We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your protected health information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out of pocket" in full.** If we do agree we will comply with your request unless the information is required by law, or is needed to provide you with emergency treatment. In order to request a restriction in our use or disclosure of your protected health information, you must make your request in writing to: **Peter Tallas – CEO: 33 Riverside Drive Suite 200, Pembroke, MA 02359**. Your request must describe in a clear and concise fashion: (a) information you wish restricted; (b) whether you are requesting to limit our company's use, disclosure or both; and (c) to whom you want limits to apply.

6. Breach. You have the right to be notified upon a breach of any of your unsecured protected health information.

7. Accounting of Disclosure. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain disclosures our organization has made of your protected health information. In order to obtain an accounting of disclosures, you must submit your request in writing to, **Peter Tallas – CEO; 33 Riverside Drive Suite 200, Pembroke, MA 02359**. All requests for an "accounting of disclosures" must state a time period which may not be longer than six years from the date of your request. The first list you request within a 12-month period is free of charge, but our company may charge you for additional lists within the same 12-month period. Our organization will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

8. Fundraising. Entities that may use or disclose your protected health information for the purpose of fundraising activities are required to inform you of such and offer you the opportunity to opt out of participation in any fundraising activities in which your protected health information may be used or disclosed. Our organization does not engage in any fundraising activities that would involve the use or disclosure of your protected health information.

9. Right to Provide an Authorization for Other Uses and Disclosures. Our organization will obtain your written authorization for uses and disclosures that are not covered by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your protected health information may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your protected health information for the reasons described in the authorization. Please note, we are required to retain records of services and items provided to you.

10. Confidential Communications. You have the right to request that our organization communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to: **Peter Tallas – CEO; 33 Riverside Drive Suite 200, Pembroke, MA 02359**, specifying the requested method of contact, or the location where you wish to be contacted. Our organization will accommodate **reasonable** requests. You do not need to give a reason for your request.

11. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our organization or with the Secretary of the Department of Health and Human Services. To file a complaint with our organization, contact **Peter Tallas – CEO; 33 Riverside Drive Suite 200, Pembroke, MA 02359**. All complaints must be submitted in writing. **You will not be penalized for filling a complaint**.

12. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact **Peter Tallas – CEO; 33 Riverside Drive Suite 200, Pembroke, MA 02359**.

OJMEDTECH

BILLING AND REIMBURSEMENT PRACTICES

Our mission at OJ Medtech is to offer our clients outstanding service and simplify the way that medical supplies are ordered and received. OJ Medtech manages all of the requirements associated with ordering supplies under Medicare, Medicaid, and other insurance plans for clients, such as obtaining prescriptions, letters of medical necessity and insurance prior approvals, if required. Our client service representatives help clients determine their insurance coverage and bill the insurance(s) on their behalf. By signing the *Patient Agreement*, the client authorizes OJ Medtech to request on their behalf, and to collect directly, all public and private insurance coverage benefits due for products and services supplied by the Company. In the event payments for insurance benefits are made directly to the client, they agree to accept all responsibility for payments due.

Deliveries are made, as requested by the client, until the item(s) are no longer medically necessary, and/or the client is deemed ineligible to receive the supplies.

The clients' insurance eligibility is verified to ensure coverage for products to be delivered. **If the client is deemed *ineligible* for the date of service, the supplies requested *CANNOT* be delivered.** However**,** deliveries may resume as soon as the client is determined to be eligible again.

Patient Financial Obligations: You are responsible for any co-payment amount indicated by your health insurance plan coverage at the time the service is rendered. You will be responsible for any co-insurance and or deductible amounts applied to your claim by your health insurance plan. OJ Medtech, Inc. will bill you for any co-insurance and or deductible amounts once your claim has been processed. We accept most major credit cards, including Mastercard, Visa, Discover, and American Express.

RETURNED GOODS POLICY

Products delivered to clients may be returned if the product is defective, the incorrect product or quantity of product, or any other acceptable reason as determined by Management.

If, for whatever reason, you are not completely satisfied with your purchase, you can return or exchange the product to OJ Medtech within **14 days of purchase.** Please contact OJ Medtech prior to sending back any returns. All returns and exchanges must be new and returned in their original product packaging. Garments that have been tried on must be laundered (using warm water and a gentle detergent) prior to return. If you are sending the item back for exchange, please allow 7-10 business days for the replacement to be processed. Note; customized garments are not available for exchange.

The client agrees to inform OJ Medtech whenever there are any changes to residence, physician, insurance carrier or prescription. Failure to notify OJ Medtech may result in the client being responsible for 100% of the charges for the supplies which were delivered.

INSURANCES COVERED

Aetna	Medicare	United Healthcare
CDPHP	Medicaid	United Empire
Healthfirst	BCBS of Eastern NY	*AND MORE**
Oxford	BCBS of Western NY	

** PLEASE NOTE THAT COVERAGES OF PRODUCTS AND COVERAGE LEVELS VARY BY PLAN. IF YOU DO NOT SEE YOUR INSURANCE LISTED HERE, PLEASE CALL CUSTOMER SERVICE FOR MORE INFORMATION. SOME EXCEPTIONS MAY APPLY.*

For questions about your billing or insurance coverage, please call Customer Service at
(888) 414-9737

OJMEDTECH

PATIENT'S RIGHTS AND RESPONSIBILITIES

As a patient you have the *right* to:

1. Choose your provider of home medical supplies and equipment.
2. Refuse service within the confines of the law and be given information concerning consequence of refusing services.
3. Receive a timely response from OJ Medtech regarding your request for home medical supplies and equipment.
4. Be given appropriate service without discrimination due to diagnosis, race, creed, color, religion, sex, national origin, sexual preference, handicap, disability or age.
5. Be treated with courtesy and respect by all OJ Medtech personnel who provide service to you, in addition to being free from physical and mental abuse, neglect and exploitative practices.
6. Be given proper identification by name and title of all OJ Medtech personnel who provide service to you.
7. Be given all necessary information, in a manner you can understand, so that you will be able to give informed consent for your services.
8. Receive complete privacy and confidentiality with regard to your condition, diagnosis, records, files, and any other personal health information or pertinent data as mandated by federal HIPAA regulations.
9. Access and review your records as mandated by federal HIPAA regulations.
10. Be involved in the planning and ordering process in addition to being notified of any changes in your medical equipment and/or supply services.
11. Register any complaints regarding services with us and/or appropriate federal and state agencies without fear of discrimination or unreasonable interruption of services. Patients may call our office with any complaints, grievances, and/or recommendations for change. Patients may also call their own health insurance plan or Medicare at 1-800-633-4227. (*Please see the* Patient Complaints/Grievances Policy *included with the information packet for further information on our complaint policy and procedure.)*
12. Rent or purchase inexpensive/routinely purchased Medicare items.

As a patient you have the *responsibility* to:

1. ***Promptly complete, date, sign and return each delivery ticket*** per delivery received, as provided to you, to OJ Medtech.
2. ***Confirm*** supplies needed each time you need a refill.
3. ***Inform*** OJ Medtech of ***any*** changes in your health insurance or other third party payer coverage.
4. ***Inform*** OJ Medtech of ***any*** changes in your address or telephone number.
5. ***Inform*** OJ Medtech if you are under the care plan of another Home Medical Equipment provider.
6. ***Provide accurate and complete health information*** and report any unexpected changes in your condition to your physician, as this may require a change in your home medical equipment and supplies.
7. ***Meet financial commitments*** by promptly meeting any financial obligation agreed to with OJ Medtech. Patient is financially responsible for invoices not covered due to ineligibility on date of service. Patient has the option to return the unused/unopened product per the guidelines of the Return Policy. *(Please see the* Billing and Reimbursement Practices *and* Patient Responsibility *documents included with the information packet for more information).*
8. ***Follow instructions*** on the care, use and maintenance of equipment and return rental equipment, if applicable, in good condition.
9. ***Show respect*** and consideration for OJ Medtech personnel and property.
10. ***Provide feedback*** to OJ Medtech regarding service needs and expectations.
11. ***Read, complete & sign the Notice of Privacy Practices*** included with this information packet, as well as the Patient Acknowledgement of Documentation Receipt and Assignment of Benefits Statement.
12. ***Request*** further information concerning anything you do not understand.

PATIENT AGREEMENT

REQUEST FOR PROVISION OF SERVICES

I understand that by acknowledging that I have been provided with this agreement, I indicate my wish to purchase health care products or services or both from OJ Medtech

INDICATION OF MEDICAL RESPONSIBILITY

I understand that I am signing under the supervision and control of my attending physician. I understand that OJ Medtech services do not include diagnostic, prescriptive or other functions typically performed by licensed physicians, and that my physician is solely responsible for diagnosing and prescribing drugs, supplies, equipment and services for my condition and otherwise supervising and controlling my medical care.

HEALTH INSURANCE INFORMATION

I agree to notify OJ Medtech of any changes to my health insurance, to include any addition or termination of a health insurance plan / coverage and or if another third party payer is responsible for coverage of my services.

CREDIT CHECK AUTHORIZATION AND CREDIT TERMS

OJ Medtech is authorized to verify any information I have disclosed and perform a credit investigation for the purpose of extending credit, if applicable, for the purchase or rental of medical equipment. In addition, OJ Medtech may answer questions from other creditors about my credit and account experience with OJ Medtech.

ASSIGNMENT OF BENEFITS

I authorize OJ Medtech to request on my behalf, and to collect directly, all public and private insurance coverage benefits due for products and services provided by OJ Medtech. In the event payments for insurance benefits are made directly to me, the payee, I will endorse all checks for payment to OJ Medtech. I accept all responsibility for overpayments per statement.

EXTENDED MEDICARE ASSIGNMENT

I certify that the information given by me for payment under Medicare (Title XVIII of the Social Security Act) and/or other medical insurance is correct.

1. **The patient, if physically and mentally competent, must sign on his/her behalf. If he/she cannot sign for himself / herself, a representative payee as designated by the Social Security Administration, a legally appointed guardian, a relative, a friend, a representative of an institution providing him or her care or support, or of a governmental agency providing assistance, may sign. The source of the signatory's authority should be stated (e.g. "Social Security appointed Representative Payee," or "court appointed guardian," etc.).**

2. **The acknowledgment of receipt for this form is used in lieu of the patient's signature on the "Request for Payment" HCFA-1500 (I-84) and is therefore an extension of that form. Anyone who misrepresents or falsifies essential information in making Medicare claims may, upon conviction, be subjected to fine and imprisonment under Federal law. Furthermore, in signing, the beneficiary authorizes any holder of medical or other information about himself / herself to release to the Social Security Administration or its intermediaries or carrier any information needed to process related Medicare claims. He / she further permits a copy of the authorization to be used in place of original.**

3. **On assigned claims, the provider agrees to accept the Medicare carriers' allowable amount as the full charge for covered services; the patient is responsible for the deductible, co-insurance and non-covered services. This authorization may be cancelled by mutual agreement of the provider and customer at any time by written notice to the Medicare Center.**

I request payment under the Medical Insurance Part of MEDICARE be made directly to OJ Medtech for service furnished me during the effective period of this authorization.

** *The acknowledgement of receipt portion of this Information Packet certifies that he / she has read the foregoing and received a copy. The consignee also certifies that he/she is the patient, or is duly authorized by the patient as patient's general agent, to execute the above and accept its terms.*

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CEO: *Peter Tallas* **Telephone: 888-414-9731**

OJMEDTECH

ACKNOWLEDGEMENT OF DOCUMENTATION RECEIPT AND ASSIGNMENT OF BENEFITS STATEMENT

I, the undersigned, acknowledge that I have *received*, *read and understand* the following documents provided to me from OJ Medtech. **The documents (marked with an*) are required by OJ Medtech to be signed and returned to OJ Medtech in order to initiate the delivery of products and services requested to be completed.**

I understand that the **Notice of Privacy Practices (NOPP) Acknowledgement Form *can only be completed by the individual client themselves, unless the individual has been assigned a court appointed legal guardian or is a minor child-*** *in either of these scenarios, the person legally responsible for the individual must be provided with the NOPP and sign the acknowledgment.*

- This Acknowledgement of Documentation Receipt and Assignment of Benefits Statement * (Sign and Return)
- Notice of Privacy Practices & Notice of Privacy Practices Acknowledgement Form* (Sign and Return)
- Patient Agreement
- Patient's Rights and Responsibilities
- DMEPOS Medicare Supplier Standards
- Patient Complaint/Grievances Policy
- Billing and Reimbursement Practices

X_____ _____ _____

Acknowledgement of Documentation Receipt: Patient or Authorized Party on Patient Behalf **Relationship to Patient** **Date**

_____

Patient Name – Please Print

Assignment of Benefits: I authorize OJ Medtech to request on my behalf, and to collect directly, all public and private insurance coverage benefits due for products and services provided by OJ Medtech. In the event payments for insurance benefits are made directly to me, the payee, I will endorse all checks for payment to OJ Medtech. I accept all responsibility for overpayments per statement. I acknowledge that I am responsible for any co-payments if applicable. I am responsible for any co-payment amount indicated by my health insurance plan coverage at the time the service is rendered. I will be responsible for any co-insurance and or deductible amounts applied to my claim by my health insurance plan. OJ Medtech, Inc. will bill you for any co-insurance and or deductible amounts once your claim has been processed.

And or if a Medicare Beneficiary:

Extended Assignment of Benefits: I certify that the information given by me for payment under Medicare (Title XVIII of the Social Security Act) and / or other medical insurance is correct. I have read and understood the Extended Assignment of Benefits statement on the Patient Agreement page contained within my patient information packet provided by OJ Medtech. I request payment under the Medical Insurance Part of Medicare be made directly to OJ Medtech for service furnished to me during the effective period of this authorization. **The patient, if physically and mentally competent, must sign on his or her own behalf.** If he or she cannot sign for himself / herself, a representative payee as designated by the Social Security Administration, a legally appointed guardian, a relative, friend, representative of an institution providing him / her care or support or a representative of a governmental agency providing assistance may sign. The source of the signatory's authority should be stated when the patient is unable to sign on his / her own behalf.

X_____ _____ _____

Assignment of Benefits: Patient Signature (or Other Authorized Party on Behalf of the Patient) **Relationship to Patient** **Date**

RETURN THIS COPY- *SIGNED AND DATED IN BOTH AREAS MARKED "X"-* TO OJ MEDTECH.

1973 Union Boulevard, Bay Shore, NY 11706
888-414-9737(toll free), 631-666-5444 (fax)

OJMEDTECH

Notice of Privacy Practices Acknowledgement Form

Patient Name: _____

Address: _____

I, the undersigned, hereby acknowledge that I have *received, read and understand* the "OJ Medtech Notice of Privacy Practices" (version effective date: 9/18/2013).

Please note: only the Individual Client ("Patient") named above or, if applicable, that individual's Personal Representative/Court Appointed Legal Guardian who is currently assigned legal authority to make any and all healthcare decisions may sign this form. *If the individual client has been assigned a Personal Representative/Court Appointed Legal Guardian* to make health care decisions on the individual's behalf, *the notice must be given to and acknowledgement obtained from the Personal Representative/Court Appointed Legal Guardian.

Signature: X_____**Date: X**_____

If the Individual Client ("Patient) named above is either a minor child or has had a legal guardian assigned to them by the court, and therefore is not legally able to sign on their own behalf, please arrange for the appropriate person to complete the information

Print Name: X _____ **Role: X**_____
(Parent of minor child, court appointed guardian, etc.)

********** **Below Section for use of OJ Medtech Staff Only** **********

If the Individual Client or, if applicable, Personal Representative/Court Appointed Legal Guardian did not sign above after multiple attempts to obtain this acknowledgment, OJ Medtech Staff must document when and how the notice was provided to the individual and/or Personal Representative/Court Appointed Legal Guardian, why the acknowledgement could not be obtained, and those efforts that were made to obtain it.

Copy of the Notice of Privacy Practices was provided to the Individual client or, if applicable, to the individual's Personal Representative/Court Appointed Legal Guardian, _____, by:

☐ Face to Face Meeting ☐ Mailing ☐ Email ☐ Other: _____ Date: _____

Documentation of Reason Client/Personal Representative/Court Appointed Legal Guardian Signature Not Obtained

☐ Client/Personal Representative/Court Appointed Legal Guardian chose not to sign
☐ Client/Personal Representative/Court Appointed Legal Guardian did not respond after a minimum of **two** attempts on the part of OJ Medtech staff to gain this acknowledgement
☐ Other: _____

Documentation of Efforts to Obtain Signed Acknowledgment of Notice of Privacy Practices

The following good faith efforts were made to obtain the Individual Client/Personal Representative/Court Appointed Legal Guardian's signature. Please document with detail (e.g., date(s), Time(s), individuals spoken to and outcome of attempts) the efforts that were made to obtain the signature. More than one attempt must have been made:

☐ Face to face presentation(s) _____
☐ Telephone contact(s) _____
☐ Certified Mailing_____
☐ Other_____

Staff Signature: _____ Title: _____

Print Name: _____ Date: _____

RETURN THIS COPY – SIGNED AND DATED TO OJ MEDTECH

1973 Union Boulevard, Bay Shore, NY 11706
888-414-9737(toll free), 631-666-5444 (fax)