

SECTION A

<hr/>	<hr/>	<hr/>	<hr/>	<hr/>
Date	Name	MI	Gender <input type="checkbox"/> F <input type="checkbox"/> M	
<hr/>	<hr/>	<hr/>	<hr/>	
Date of Birth	SSN	Primary Language Spoken by Client		
<hr/>	<hr/>	<hr/>	<hr/>	<hr/>
Facility Name (If Applicable)	Wing	Room#	Bed#	
<hr/>	<hr/>	<hr/>	<hr/>	<hr/>
Physical Address	City	State	Zip	Phone
<hr/>	<hr/>	<hr/>	<hr/>	<hr/>
Client Billing Address (If Different)	City	State	Zip	Phone
<hr/>	<hr/>	<hr/>	<hr/>	<hr/>
Caregiver Name	Relation	Phone		
<hr/>	<hr/>	<hr/>		
Emergency Contact	Phone			
<hr/>	<hr/>			
Email Address	<hr/>			
<input type="checkbox"/> Power of Attorney	<input type="checkbox"/> Legal Guardian			<hr/>
<hr/>	<hr/>	<hr/>	<hr/>	<hr/>
	Name	Phone		
<hr/>	<hr/>	<hr/>	<hr/>	<hr/>
Primary Physician or Hospital	Care Coordinator Name	Phone		

SECTION B

PLEASE INCLUDE COPIES OF ALL APPLICABLE INSURANCE CARDS

<hr/>	<hr/>
Primary Insurance Company	Phone
<hr/>	<hr/>
Primary Policy Holder	Relationship
<hr/>	<hr/>
Primary Insured SSN #	Date of Birth
<hr/>	<hr/>
Insured's ID #	Group Number

<hr/>	<hr/>
Secondary Insurance Company	Phone
<hr/>	<hr/>
Primary Policy Holder	Relationship
<hr/>	<hr/>
Primary Insured SSN #	Date of Birth
<hr/>	<hr/>
Insured's ID #	Group Number

WORKER'S COMPENSATION

<hr/>	<hr/>
Insurance Company Name	Phone
<hr/>	<hr/>
Employer Name	City State Zip
<hr/>	<hr/>
Claim Number	Date of Injury

AUTO INSURANCE

<hr/>	<hr/>
Name of Auto Insurance	Phone
<hr/>	<hr/>
Claim Number	Date of Injury

All of the following standards are offered in the form of an informational brochure and packet: Location and Compliance Contact Information / Authorization & Assignment of Benefits / Financial Responsibility Notice / Notice of Privacy Practices / Client Bill of Rights and Responsibilities / Client Emergency Preparedness Sheet / Client Infection Control Sheet / Medicare Supplier Standards.

ACKNOWLEDGMENT OF PATIENT INTAKE FORM

AUTHORIZATION OF SERVICE/CARE:

The client understands that their signature on the acknowledgment form of this agreement authorizes Geneva Woods Health Supplies, LLC and/or its subsidiaries (GWHS) to provide products and/or services to them. The client also understand that the products and/or services provided to them by GWHS, or its employees, are provided under the direction of their prescriber and that GWHS is not liable for any act, injury, damage, or omission when following the instructions of said prescriber.

RENTAL/SALES TERMS:

The client understands that equipment rented under this agreement remains the property of GWHS and agrees not to assign possession rights of the rental equipment. Title to the equipment does not transfer to them until equipment is purchased and paid for in full. The client agrees to return the equipment in the same condition, as it was when received, normal wear and tear excluded. Rental charges will continue until equipment is returned to GWHS. The client understands they will be charged the full retail amount of any rental equipment that fails to be returned, is lost, or damaged resulting from negligence, theft, fire, abuse, accident, or any other cause other than reasonable wear. GWHS shall replace or repair defective equipment in a timely manner. GWHS shall not be responsible for incidental or consequential damage due to clients' failure to timely notify GWHS of any malfunction/defect or any unauthorized modifications made to rental equipment. The client understands that they will return rental equipment when there is no longer a medical necessity for it. The client agrees to notify GWHS if they move, enter a nursing facility of any kind, enter a hospital, or become a hospice patient. The client understands that Medicare Part B does not cover rental of this equipment while the patient is in a nursing facility. The client will notify GWHS in the event of these occurrences. The client agrees to not move any equipment without prior permission from GWHS. GWHS honors all warranties expressed and implied under applicable state law. GWHS will not charge for the repair or replacement of Medicare covered items/services covered under warranty. GWHS advises Medicare beneficiaries that they may either rent or purchase inexpensive or routinely purchased durable medical equipment (DME). Sales returns will be accepted in unopened packages and/or saleable condition within thirty (30) days from date of original invoice with proof of purchase. No merchandise will be accepted for return if worn next to the skin, used for sanitary or hygienic purposes or if it is disposable (i.e. oxygen, underpads or diapers, lancets, enterals, compression garments, creams, sprays, gels). Special order items may require a deposit and are non-returnable.

ASSIGNMENT OF INSURANCE BENEFITS:

The client authorizes direct payment to GWHS of any insurance benefits otherwise payable to them for products or services provided by GWHS or agents. The client also authorizes their insurance company, including Medicare and Medicaid, to provide to employees of GWHS any and all information regarding to their insurance benefits and status of claims submitted by GWHS for services rendered. This authorization is in effect until the patient chooses to revoke it in writing.

ACKNOWLEDGMENT OF MY FINANCIAL RESPONSIBILITY:

The client understands that their insurance coverage may not pay the total cost of the equipment, products, or services provided to them by GWHS. The client acknowledges their obligation to pay the balance between what their insurance coverage will pay and what GWHS charges for equipment, products, or services. The client further acknowledges that they will be responsible to pay, within 60 days from the date that the claim was submitted to their insurance payer, for the full amount of charges associated with any products, or services they receive from GWHS should their insurance payer deny payment for any reason including, but not limited to, their failure to qualify for any products, or services, non-coverage by their insurance payer, or their failure to provide complete and accurate information to GWHS necessary for billing their insurance payer. GWHS shall have the right to pick up all equipment if financial responsibilities are not met. The client authorizes GWHS to initiate a complaint to the Insurance Commissioner on their behalf. The client agrees to remit to GWHS any payments made directly to them by their insurance payer for products provided by GWHS. The client agrees to be responsible for their co-payment and/or annual deductible amounts. Individual patient statements are mailed out on a per invoice basis, and are due twenty days from the date of the statement, unless otherwise indicated. Facility and/or private payor statements are due according to the terms of the contract and/or the terms indicated on the monthly statement. Payments can be mailed or taken over the phone by our Accounts Receivable Department. We accept cash, personal checks, company checks, money orders, and credit cards. We also make credit card pre-payment arrangements for anticipated monthly client balances. A \$30.00 late fee may be added beginning on the 61st day and monthly until the balance is paid in full. GWHS will be entitled to the full amount due on the account including but not limited to attorney fees and/or collection fees that may accrue. Also, in the case of default, the client authorizes GWHS to attach all rights to their Alaska State Permanent Fund Dividend until all financial obligations are met (where applicable).

CONSENT REQUEST-THE TELEPHONE CONSUMER PROTECTION ACT (TCPA):

The Telephone Consumer Protection Act (TCPA) was passed by Congress, and all institutions/suppliers are required to obtain consent before contacting a client on their mobile or residential phone. To ensure you do not miss any important communications, we are requesting permission to contact you via Virtual Agent, direct dial, or text messages (if applicable) on your residential or mobile phone. You may choose to opt out of contacts to your mobile phone(s). GWHS does not engage in telemarketing. By signing below, you indicate your consent to be contacted on any mobile or residential number on file, and that you have the authority to provide consent (message and data rates may apply for your mobile service plan). You may withdraw the consent to be contacted on your wireless telephone number(s) at any time by written notice to GWHS, 501 W Int'l Airport Rd, Ste 1A, Anchorage, AK 99518.

I do not consent

**SIGN
HERE**



This agreement is binding as long as I am receiving equipment, products, or services FROM Geneva Woods Health Supplies, LLC and/or its subsidiaries. The word "client" is understood to be the person receiving medical equipment, and/or supplies FROM Geneva Woods Health Supplies, LLC. and/or its subsidiaries.

Client Name _____

Signature of Client or Client's Legal Representative _____

Date _____

Printed Name of Client's Legal Representative _____

Relationship to Client _____