GARRETT'S MEDICAL SUPPLY, INC
PATIENT INTAKE FORM

Discharge Planner (Referral Source): _____
Hospital (If applicable): _____

Patient Information

Last Name_____ Full First Name_____
Address_____
City_____State_____Zip_____
Phone: _____
Gender: □ Male □ Female Date of Birth:_____ SSN:_____

Ordering/Prescribing Physician_____ License #_____
Address_____ Phone #_____

Follow Up Physician_____License #_____
Address_____ Phone #_____

Related Diagnoses for Service(s) Provided _____

_____

Patient Height: _____ Patient: Weight:_____

Emergency Contact Person_____
Address_____ Phone #_____

Next of Kin/Legal Guardian_____ Phone #_____

Primary Caregiver_____ Phone #_____

Person Responsible for Bill _____
Address_____ Phone #_____

Insurance Coverage

#1_____Policy #_____
Address_____ Phone #_____
Name of Insured: _____ Date of Birth: _____

#2_____Policy #_____
Address_____ Phone #_____
Name of Insured: _____ Date of Birth: _____

#3_____Policy # _____
Address_____ Phone #_____
Name of Insured: _____ Date of Birth: _____

Service Begin Date_____

Patient Currently Hospitalized? ❑ Yes ❑ No

If Yes, Name of Hospital_____
Phone #:_____Room #_____ Discharge Date_____

Name(s) of other home health providers visiting patient:_____

_____

Services

❑ Oxygen

❑ LOX LPM_____ Method_____
Hours per Day_____ Portable Required?_____ Type_____
❑ Pulse Oximeter_____
❑ Other Respiratory Care Equipment_____
_____

❑ Home Blood Glucose Meter Meter Type: _____
Supplies: ❑ Strips ❑ Lancets ❑ Lancet Device ❑ Control Solution
❑ Walker_____
❑ Bath Aids_____
❑ Bedside Commode_____
❑ Wheelchair_____
❑ Fitter Services_____
❑ Home Healthcare Supplies_____
_____

Person Taking Referral: _____ Date received:_____

Patient Contacted: Date:_____Time:_____ Expected Delivery Date:_____Time:__
_____

Form Revised: 03/16/2012

PATIENT CALL-BACK FORM

PATIENT NAME:_____

TELEPHONE NUMBER:_____DATE OF SET-UP:_____

EQUIPMENT/SUPPLIES THAT WERE SET UP:_____

_____

_____

CALL-BACK DATE:_____

ARE THERE PROBLEMS OR QUESTIONS? □ YES □ NO

IF YES, DESCRIBE:_____

_____

PROBLEMS AND/OR QUESTION(S) RESOLVED: □ YES □ NO □ N/A

DESCRIPTION OF RESOLUTION: _____

_____

DATE OF RESOLUTION: _____

Signature of staff member who completed this form:

_____

Please print staff member's name: _____

Form Revised: 03/16/2012

GARRETT'S MEDICAL SUPPLY, INC
PATIENT SERVICE AGREEMENT

Patient Name: _____ ID _____

Authorization/Consent for Care/Service: I have been informed of the home care options available to me and of the selection of providers from which I may choose. I authorize GARRETT'S MEDICAL SUPPLY, INC under the direction of the prescribing physician, to provide home medical equipment, supplies and services as prescribed by my physician.

Assignment of Benefits/Authorization for Payment: I hereby assign all benefits and payments to be made directly GARRETT'S MEDICAL SUPPLY, INC, for any home medical equipment, supplies and services furnished to me in conjunction with my home care. I authorize GARRETT'S MEDICAL SUPPLY, INC to seek such benefits and payments on my behalf. It is understood that, as a courtesy. GARRETT'S MEDICAL SUPPLY, INC will bill Medicare/Medicaid or other federally funded sources and other payers and insurer(s) providing coverage, with a copy to GARRETT'S MEDICAL SUPPLY, INC I understand that I am responsible for providing all necessary information and for making sure all certification and enrollment requirements are fulfilled. Any changes in the policy must be reported to GARRETT'S MEDICAL SUPPLY, INC within 30 days of the event. I have been informed by GARRETT'S MEDICAL SUPPLY, INC of the medical necessity for the services prescribed by my physician. I understand that in the event services are deemed not reasonable and necessary, payment may be denied and that I will be fully responsible for payment.

Release of Information: I hereby request and authorize GARRETT'S MEDICAL SUPPLY, INC, the prescribing physician, hospital, and any other holder of information relevant to service, to release information upon request, to GARRETT'S MEDICAL SUPPLY, INC, any payer source, physician, or any other medical personnel or agency involved with service. I also authorize GARRETT'S MEDICAL SUPPLY, INC to review medical history and payer information for the purpose of providing home health care.

Financial Responsibility: I understand and agree that I am responsible for the payment of any and all sums that may become due for the services provided. These sums include, but are not limited to, all deductibles, co-payments, out-of-pocket requirements, and non-covered services. If for any reason and to any extent, GARRETT'S MEDICAL SUPPLY, INC does not receive payment from my payer source, I hereby agree to pay GARRETT'S MEDICAL SUPPLY, INC for the balance in full, within 30 days of receipt of invoice. All charges not paid within 45 days of billing date shall be assessed late charges. I am liable for all charges, including collection costs and all attorneys cost. I am responsible for all charges regardless of my payer unless my agreement with my health plan holds me harmless.

_____ (Initials) I acknowledge that I have been advised of my financial obligations to GARRETT'S MEDICAL SUPPLY, INC.

Returned Goods: I understand that, due to Federal and State Pharmacy Regulations ancillary items prescribed for home health care cannot be re-dispensed. Therefore, ancillary items cannot be returned for credit. Home Medical Equipment that is rented will be returned after the physician has discontinued service. Sale items cannot be returned. GARRETT'S MEDICAL SUPPLY, INC must be notified within 24 hours of the set-up if any equipment is defective. In the case of defective equipment, an exchange will be made for the defective item.

Patient Handouts: I acknowledge that I have received a copy of the Patient Handouts which contains Patient Rights and Responsibilities, Supplier Standards, Home Safety Information, HIPAA Privacy Standards, Emergency Planning, and Advance Directive Information. I acknowledge that the information in the Patient Handouts has been explained to me and that I understand the information. I understand my right to formulate and to issue Advance Directives to be followed should I become incapacitated. I will furnish GARRETT'S MEDICAL SUPPLY, INC with a copy of such document.

Grievance Reporting: I acknowledge that I have been informed of the procedure to report a grievance should I become dissatisfied with any portion of my home care experience. I understand that I may lodge a complaint without concern for reprisal, discrimination, or unreasonable interruption of service. To place a grievance, please call 863-293-9747 and speak to the Customer Services Supervisor. If your complaint is not resolved to your satisfaction within 5 working days, you may initiate a formal grievance, in writing and forward it to the Governing Body. You can expect a written response within 14 working days or receipt.

Home Health Hotline: You may also make inquiries or complaints about this company by calling your local Social Services Department and/or the Accreditation Commission for Health Care (ACHC) at 919-785-1214.

Patient: _____ Date: _____

Witness: _____ Date: _____

Form Revised: 03/16/2012

GARRETT'S MEDICAL SUPPLY, INC

PATIENT SATISFACTION SURVEY

Patient Name (Optional):_____

City, State:_____ Date:_____

It is our desire to provide you with the best quality home care services available. In order to help us maintain our high standards, please take a few moments to tell us how we are doing. Please complete this form and note the response that most closely matches your experience.

REGARDING GARRETT'S MEDICAL SUPPLY, INC	Extremely Satisfied	Satisfied	Dissatisfied	Extremely Dissatisfied
Services/Equipment were provided in a timely manner				
My home care needs were met through the services/equipment provided				
The staff discussed my rights and responsibilities and financial obligations				
The staff informed me how to contact the office during and after hours				
I would utilize/recommend GARRETT'S MEDICAL SUPPLY, INC to my friends or family				
REGARDING THE STAFF OF GARRETT'S MEDICAL SUPPLY, INC	Extremely Satisfied	Satisfied	Dissatisfied	Extremely Dissatisfied
The representatives were courteous and professional				
Explanations and instructions offered by representatives were adequate				
All procedures/services were explained prior to performing them				
Equipment was delivered clean and in good working order				
My personal property was treated with respect				

Comments:

Please return the survey to GARRETT'S MEDICAL SUPPLY, INC in the envelope provided.

Thank you for choosing GARRETT'S MEDICAL SUPPLY, INC.