KEYSTONE
MEDICAL SUPPLIES

Patient Service Agreement

Phone: 769-567-1240
Fax: 844-567-1272
Toll free: 833-847-1240

Patient Name: _____ **Date of Birth:** _____

Place of Service: _____ **Physician:** _____ **Phone Number:** _____

Medicare Part B # *(If Eligible)*: _____ **Effective Date:** _____

Medicaid I.D. # *(If Eligible)*: _____ **State:** _____

Other Insurance: _____ **Group:** _____

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 Keystone 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 to Keystone for any home medical equipment, supplies and services furnished to me in conjunction with my home care. I authorize Keystone to seek such benefits and payments on my behalf. It is understood that, as a courtesy, Keystone will bill Medicare/Medicaid or other federally funded sources and other payers and insurer(s) providing coverage, with a copy to Keystone. 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 Keystone within 30 days of the event. I have been informed by Keystone 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 Keystone, the prescribing physician, hospital, and any other holder of information relevant to service to release information upon request to Keystone, any payer source, physician, or any other medical personnel or agency involved with service. I also authorize Keystone 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 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, Keystone does not receive payment from my payer source, I hereby agree to pay Keystone. I also understand that I may be eligible for a partial or complete waiver of any unpaid co-insurance charges only under the Keystone financial hardship program.

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. Keystone must be notified within 24 hours of 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 contain 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 Keystone with a copy of such document. I have been instructed on and understand the use of the products provided. I have received the products ordered. I have received the product manual/instructions, warranty information, and instructions to follow up with Keystone.

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 833-847-1240 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 of receipt. You may also make inquiries or complaints about this company by calling the Mississippi Board of Pharmacy and/or the Accreditation Commission for Health Care (ACHC) at 919-785-1214.

Client or Responsible Party Signature: _____ **Date:** _____

If beneficiary is unable to sign:

Authorized Signature: _____ **Title:** _____

Reason Patient is unable to sign: _____

Keystone Employee Signature: _____ **Date:** _____