HIPAA NOTICE OF PRIVACY PRACTICES

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

Star Medical Specialties
Addison, Texas

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by our organization, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the organization, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for equipment or supplies coverage may require that your relevant protected health information be disclosed to the health plan to obtain approval for coverage.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of our organization. These activities include, but are not limited to, quality assessment activities, employee review activities, accreditation activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to accrediting agencies as part of an accreditation survey. We may also call you by name while you are at our facility. We may use or disclose your protected health information, as necessary, to contact you to check the status of your equipment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Criminal Activity, inmates, Military Activity, National Security, and Workers' Compensation. Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or this organization has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members pr friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Our organization is not required to agree to a restriction that you may request. If our organization believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively (i.e., electronically).

You may have the right to have our organization amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before April 14, 2003

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information, if you have any questions concerning or objections to this form, please ask to speak with our HIPAA Compliance Officer (General Manager) in person or by phone at 972-380-2065.

Your signature below acknowledges that you have received a copy of this Notice of our Privacy Practices.

Print Name:_____ Date: _____

Signature:_____

Form Revised: 08/20/2007

Star Medical Specialties
CLIENT/PATIENT SERVICE AGREEMENT

Client/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 Star Medical Specialties 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 Star Medical Specialties, Inc for any home medical equipment, supplies and services furnished to me in conjunction with my home care. I authorize Star Medical Specialties to seek such benefits and payments on my behalf. It is understood that, as a courtesy, Star Medical Specialties will bill Medicare/Medicaid or other federally funded sources and other payors and insurer(s) providing coverage, with a copy to Star Medical Specialties 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 Star Medical Specialties within 30 days of the event. I have been informed by Star Medical Specialties 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 Star Medical Specialties, the prescribing physician, hospital, and any other holder of information relevant to service, to release information upon request, to Star Medical Specialties, any payor source, physician, or any other medical personnel or agency involved with service. I also authorize Star Medical Specialties to review medical history and payor 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, Star Medical Specialties does not receive payment from my payor source, I hereby agree to pay Star Medical Specialties 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 payor unless my agreement with my health plan holds me harmless.

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. Star Medical Specialties 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.

Client/Patient Handouts: I acknowledge that I have received a copy of the Client/patient Handouts which contains Client/patient Rights and Responsibilities, Supplier Standards, Home Safety Information, HIPPA Privacy Standards, Emergency Planning, and Advance Directive Information. I acknowledge that the information in the Client/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 Star Medical Specialties 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 972-380-2065 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 7 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 CHAP. **HHS-TIPS HOTLINE: 1-800-447-8477, Mon – Fri, 8am-5:30pm EST. CHAP: 1-800-656-9656, 24 hours.**

Client/patient: _____ Date: _____

Witness: _____ Date: _____

Form Revised: 08/20/2010

Star Medical Specialties
EQUIPMENT MANAGEMENT ADMISSION ASSESSMENT AND PLAN OF SERVICE

CLIENT NAME_____ ADMISSION DATE_____
ADDRESS_____
PHONE _____EMERGENCY CONTACT_____
SEX _____ DATE OF BIRTH _____HOSPITAL D/C DATE_____
DIAGNOSIS _____PHYSICIAN_____
PHYSICIAN'S ORDERS_____
_____
OTHER INDIVIDUALS/ORGANIZATIONS INVOLVED IN CLIENT'S CARE:_____

HOME ASSESSMENT-ENVIRONMENTAL/SAFETY/FALLS

ARCHITECTURAL BARRIERS ☐ ADEQUATE ☐ INADEQUATE
SHELTER, HEAT, WATER, PLUMBING, REFRIGERATION, COOKING ☐ ADEQUATE ☐ INADEQUATE
ELECTRICAL (check ground, no use of extension cords) ☐ ADEQUATE ☐ INADEQUATE
FIRE SAFETY (has smoke detector/alarm and extinguisher) ☐ ADEQUATE ☐ INADEQUATE
DOES ANYONE SMOKE IN THE HOME? _____NUMBER PERSONS LIVING IN HOME?_____
FALLS ASSESSMENT COMPLETED AND CDC HANDOUTS REVIEWED? ☐ YES ☐ NO
ANY FALLS HAZARDS DETERMINED DURING ASSESSMENT? ☐ YES ☐ NO, IF YES, DOCUMENT CONCERNS AND INFORMATION GIVEN THE CLIENT:_____
_____
ANY OTHER SAFETY OR HEALTH HAZARDS? COMMENTS:_____
SUITABLE FOR HOME CARE? ☐ YES ☐ NO, IF NO, DOCUMENT CONCERNS AND INFORMATION GIVEN THE CLIENT:_____
_____

EQUIPMENT INFORMATION

1. Manufacturer: _____ Model: _____Serial #:_____
Hours: _____ Setting(s):_____
Next PM Due: Date _____ Hours:_____PM Sticker Present: ☐ Yes ☐ No

2. Manufacturer: _____ Model: _____Serial #:_____
Hours: _____ Setting(s):_____
Next PM Due: Date _____ Hours:_____PM Sticker Present: ☐ Yes ☐ No

3. Manufacturer: _____ Model: _____Serial #:_____
Hours: _____ Setting(s):_____
Next PM Due: Date _____ Hours:_____PM Sticker Present: ☐ Yes ☐ No

4. Manufacturer: _____ Model: _____Serial #:_____
Hours: _____ Setting(s):_____
Next PM Due: Date _____ Hours:_____PM Sticker Present: ☐ Yes ☐ No

SUPPLIES DISPENSED

PLAN OF SERVICE

Identified Needs/Problems:
- ☐ The client is unfamiliar with use and maintenance of the home medical equipment.
- ☐ The client is uncertain of home safety.
- ☐ The client may be required to troubleshoot the equipment or use back-up equipment.
- ☐ The client may require follow-up services.

Expected Outcomes:
- ☐ The client will be provided prescribed equipment to comply with the physician's prescription.
- ☐ The client will use the home medical equipment as prescribed by the physician.
- ☐ The client will use and maintain home medical equipment in a safe/proper manner.
- ☐ The client will adhere to home safety guidelines.
- ☐ The client will be able to troubleshoot any equipment problems and/or use back-up system.
- ☐ The client will know how to obtain follow-up services as needed.

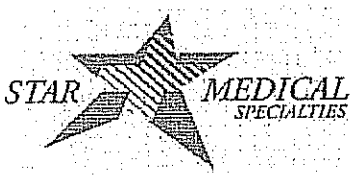
Services/Actions Provided:
- ☐ Deliver and set-up home medical equipment at a mutually agreed upon time and place.
- ☐ Provide training in safe/proper use and maintenance of all home medical equipment.
- ☐ Provide training and written handout in client rights and responsibilities, supplier standards, home safety, HIPPA Privacy standards, emergency planning and provide financial responsibilities
- ☐ Demonstrate troubleshooting of equipment and correct use of back-up system (if provided).
- ☐ Provide written instructions for use of the home medical equipment.
- ☐ Provide written instructions for obtaining routine/emergency follow-up services
- ☐ For equipment sold to the client the warranty card(s) are given to the client. Mark NA if no sale items are provided

Caregiver Demonstrates proper use of equipment.
Initials:

Equipment is functioning properly at the time of set-up.
Initials:

I acknowledge training in the use of equipment and products provided and the performance of the Equipment Management Admission Assessment and Plan of Service on the date noted: **I have been instructed to call 972-380-2065 for Star Medical Specialties after hours.**
Form Revised:10/16/2013

_____ _____ _____
Client/Patient Signature Date Staff Member Form Revised: 10/14/2013



EQUIPMENT WARRANTY INFORMATION FORM

Date: _____

Name of the Patient: _____

Every product sold or rented by Star Medical Specialties carries a 2-year manufacturer's warranty. We notify all Medicare/Medicaid beneficiaries of the warranty coverage, and that we honor all warranties under applicable law. We will repair or replace, free of charge, Medicare/Medicaid covered equipment that is under warranty. In addition, an owner's manual with warranty information will be provided to beneficiaries for all durable medical equipment where this manual is available.

I have been instructed and understand the warranty coverage of the product I have received.

Beneficiary's Signature: _____ Date: _____

Star Medical Specialties
4386 Sunbelt Dr.
Addison, TX 75001
(800) 368-2065

RELEASE OF INFORMATION

Date: _____

Name of the Patient: _____

Relationship to the Patient: _____

I, _____, (patient)/ (guardian) have read and understand the HIPPA policies and authorize *Star Medical Specialties* to discuss my account, medical and/or financial, with the following people:

_____ _____
Name Relationship to Patient

_____ _____
Name Relationship to Patient

_____ _____
Name Relationship to Patient

Person to contact in case of emergency:

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

Patient's Signature: _____