Babette Maiss,CMF,CLT,CMT
13 Williamsburg Lane
Chico,CA 95926
(530) 321-5668

DMEPOS SETUP and PROOF OF DELIVERY

Patient Name:	Date of Birth:

Shipping Company	Shipping Tracking/Invoice Number	Date Shipped	Rep Initial

Quantity	Description (Model/Serial Number)	HCPCS CODE	Date of Service

Patient has: X if complete		Documents Given to the Patient:	
Been assessed for the appropriateness of the DMEPOS.	☐	Manufacturer Documentation	☐
Been trained on proper use, maintenance, and storage of Product.	☐	Warranty	☐
Been alerted to the potential risks and hazards of the DMEPOS	☐	Patient Satisfaction Survey	☐
Been shown proper setup	☐	Rental Agreement (if applicable)	☐
Been made aware of the physicians instructions	☐	HIPAA Form	☐
Been Instructed to contact the Physician for changes in condition	☐	Medicare Supplier Standarts	☐
Had their questions and concerns addressed	☐	Complaint Policy	☐

ASSIGNMENT OF BENEFITS

- I assign the right and responsibility to the Facility to bill on my behalf, and accept ASSIGNMENT FROM MY INSURANCE
- I understand that I am responsible to pay any deductible amount applied to the claims and the coinsurance amount applied to the claim.

If my insurance denies or does nor pay my claim, I agree to contact my insurance to help get it paid. I will pay my dues in 10 days after eceiving the Estimated of Benefit. A notification letter/email will be sent prior to being sent to collection and my

- balance will increase, which includes 18% interest along with 40% Attorney and collection fees.

I permit the Facility to release and collect my health information, and other information, as required (and as permitted by

- HIPAA Regulations from my Health care providers.

Patient/Caregiver Signature (Provide relationship if not the patient)	Date

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Messages and Notes for Patient and /or Caregiver

PATIENT BILL OF RIGHTS AND RESPONSIBILITES

To ensure the finest care possible, as a Patient receiving Durable Medical Equipment (DME) and our Facility services, you should understand your role, rights and responsibilities involved in your own plan of care.

Patient Rights

- To select those who provide you with DME and Facility services
- To receive the appropriate or prescribed services in a professional manner without discrimination relative to your age, sex, race, religion, ethnic origin, sexual preference or physical or mental handicap
- To be treated with friendliness, courtesy and respect by each and every individual representing our Facility, who provided treatment or services for you and be free from neglect or abuse, be it physical or mental
- To assist in the development and preparation of your plan of care that is designed to satisfy, as best as possible, your current needs, including management of pain
- To be provided with adequate information from which you can give your informed consent for commencement of services, the continuation of services, the transfer of services to another health care provider, or the termination of services
- To express concerns, grievances, or recommend modifications to your DME and Facility services, without fear of discrimination or reprisal
- To request and receive complete and up-to-date information relative to your condition, treatment, alternative treatments, risk of treatment or care plans
- To receive treatment and services within the scope of your plan of care, promptly and professionally, while being fully informed as to our Facility's policies, procedures and charges
- To request and receive data regarding treatment, services, or costs thereof, privately and with confidentially
- To be given information as it relates to the uses and disclosure of your plan of care
- To have your plan of care remain private and confidential, except as required and permitted by law

Patient Responsibilities

- To provide accurate and complete information regarding your past and present medical history
- To agree to a schedule of services and report any cancellation of scheduled appointments and/or treatments
- To participate in the development and updating of a plan of care
- To communicate whether you clearly comprehend the course of treatment and plan of care
- To comply with the plan of care and clinical instructions
- To accept responsibility for your actions, if refusing treatment or not complying with, the prescribed treatment and services
- To respect the rights of Facility personnel
- To notify your Physician and the Facility with any potential side effects and/or complications

Babette Maiss, CMF,CLT,CMT
Certified Mastectomy Fitter and Lymphedema Therapist
13 Williamsburg Lane
Chico, CA 95926

Facility STANDARDS OF BENEFICIARY SERVICE

Facility HOURS OF OPERATION

Monday	9AM-5:30PM	Lunch: 12:30PM - 2:00PM
Tuesday	9AM-5:30PM	Lunch: 12:30PM - 2:00PM
Wednesday	9AM-5:30PM	Lunch: 12:30PM - 2:00PM
Thursday	9AM-5:30PM	Lunch: 12:30PM - 2:00PM
Friday	9AM-5:30PM	Lunch: 12:30PM - 2:00PM
Saturday	CLOSED	
Sunday	CLOSED	
Holidays	CLOSED	

FACILITY PHONE NUMBERS

During Regular Business Hours 530-321-5668

DMEPOS PRODUCT REPAIR OR REPLACEMENT INFORMATION:

Babette Maiss, CMF,CLT,CMT honors all manufacturer's warranties on all items sold at Babette Maiss, CMF,CLT,CMT. All warranty issues requiring repair or replacement will include a suitable pre-approved loaner (at no cost to the beneficiary). Beneficiary or Caregiver should return the product to Babette Maiss CMF,CLT,CMT. Babette Maiss,CMF,CLT,CMT will accept the defective, broken, or otherwise non-functioning product back at our location to be sent in to the manufacturer for repair or replacement. The repair or replacement will be handled by the manufacturer.

All non-warranty repairs will be completed by the manufacturer, during which time a suitable pre-approved loaner or replacement will be available to rent or purchase. Beneficiary or Caregiver should return the product to Babette Maiss, CMF,CLT,CMT. Babette Maiss, CMF,CLT,CMT will accept the defective, broken or otherwise non-functioning product back at out location to be sent in to the manufacturer for repair.

In all cases of repair or replacement the action taken will be documented and tracked on a Product maintenance and repair form.

General product maintenance will be illustrated in depth to the beneficiary and/or caregiver, utilizing any and all manufacturer's instructions and guides on recommended maintenance.

Babette Maiss, CMF,CLT,CMT

BENEFICIARY SATISFACTION SURVEY
(DMEPOS Products/Services)

In an effort to continuously monitor and maintain the highest degree of customer satisfaction and service you receive from our Facility, please complete this survey and return to the address listed below. We highly value your opinion!

_____ _____

Date Beneficiary Name *(optional)*

DMEPOS Product/Service Received _____

Please rate your degree of satisfaction on a scale of 1 – 5.
1 indicating **Complete Dissatisfaction** and **5** indicating **Complete Satisfaction**
(Circle your Score; If Not Applicable, Circle "NA")

1. Customer Service:						
Therapist	1	2	3	4	5	NA
Facility	1	2	3	4	5	NA
2. Time Frame for Delivery of Product/Service	1	2	3	4	5	NA
3. Quality of Product/Service Received	1	2	3	4	5	NA
4. Product Ease of Use	1	2	3	4	5	NA
5. Product Set Up	1	2	3	4	5	NA
6. Training Received on Product Use	1	2	3	4	5	NA
7. Training Received on Product Care and Maintenance	1	2	3	4	5	NA
8. Product Safety	1	2	3	4	5	NA

Comments: _____

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Please Return Completed Survey to:

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