Baxter

TERMS, CONDITIONS AND RESPONSIBILITY

HFCWO Device, Service, Supplies and Accessories

Advanced Respiratory, Inc. ("ARI"), a Baxter company, is being asked to supply a High Frequency Chest Wall Oscillation (HFCWO) device, supplies and accessories (the "Equipment"). If you have questions about this form, please contact ARI's Customer Service Team at 1-800-426-4224 before signing.

PATIENT/CUSTOMER NAME: ______________________________ PATIENT ACCOUNT NUMBER: __________________

RELEASE MEDICAL RECORDS TO OTHER PROVIDER

I understand that data related to my use of the HFCWO device will be accessed, used, and/or disclosed to ARI and to my healthcare provider(s) to coordinate my care and treatment. I understand that de-identified data regarding my device use may be aggregated and reviewed by ARI and my healthcare team to provide treatment and benchmarking information.

FINANCIAL RESPONSIBILITY

I understand that ARI will work with me to obtain reimbursement from my insurance carrier(s) and has programs to support patients through the reimbursement process, including providing appeal assistance. I further understand that ARI has interest-free payment plans and patient financial assistance for those patients who qualify financially and have an established need to receive medically necessary medical services. I am responsible for any amounts not covered by my insurance carrier(s), including any applicable co-payments and deductibles. I also agree to cooperate with the reimbursement process and assist in any appeal. I acknowledge that I am able to and will promptly return the Equipment, to ARI, at no cost, if ARI is unable to obtain reimbursement from my insurance carrier(s) and I do not make other financial arrangements to pay ARI for the Equipment. It is my responsibility to return all rental Equipment to ARI if: 1) I stop using the Equipment; 2) The medical order for the Equipment ends or is discontinued; 3) I fail to make acceptable financial arrangements for any amounts not covered by my insurance carrier(s); or 4) ARI reasonably requests that I return the Equipment.

ASSIGNMENT OF BENEFITS AND AUTHORIZATION OF THIRD-PARTY PAYMENT

I authorize ARI to submit insurance carrier claims on my behalf for the products and services provided by ARI. I authorize release of medical and other information about me to my insurance company, HMO, other third-party payers, or their third party administrators, to process and pay claims, determine benefits, perform quality of care reviews or for health care operations. I request that payment of medical benefits be made directly to ARI for the Equipment provided to me by ARI. ARI accepts assignment unless ARI enters into a separate written and signed agreement with me that specifically states that ARI is not accepting assignment.

I agree to accept full financial responsibility as a patient who is receiving medical services, or as the Responsible Party for the patient. **The Responsible Party is the individual who is financially responsible for payment of bills**. My signature verifies that I understand my responsibilities and agree to these terms.

PATIENT PRINTED NAME ____________ PATIENT SIGNATURE ____________ DATE ________

RESPONSIBLE PARTY PRINTED NAME ____________ RELATIONSHIP TO PATIENT ____________

RESPONSIBLE PARTY SIGNATURE ____________ DATE ________

RESPONSIBLE PARTY ADDRESS ____________ RESPONSIBLE PARTY DATE OF BIRTH ________

CHECK REASON CUSTOMER UNABLE TO SIGN ☐ Patient/Customer is under 18 ☐ Patient / Customer is physically or cognitvely unable to sign on their own behalf

By accepting the Equipment and any replacement products which may be provided, you (patient/caregiver/legal guardian) are representing that you understand and acknowledge that your insurance carrier(s), including certain government insurance programs, may eventually require ownership of the Equipment to be transferred to the insurance program from which payment was received. In these and other cases where you do not own the Equipment, ARI may need to (re)enter the home to perform certain tasks related to title transfer activities. By accepting the Equipment, you agree to comply with all such requirements and to grant access to the home, as needed. Please contact your insurance carrier(s) if you have questions regarding transfer of product ownership.

The method of payment your insurance company will make is dependent on the Equipment you are receiving. For Medicare beneficiaries receiving a product that Medicare deems a capped rental, Medicare will pay a monthly rental fee for a period not to exceed thirteen (13) months, afterwards, ownership of the Equipment is transferred to the Medicare beneficiary. If you are receiving a product that is not deemed a Medicare capped rental, your insurance may pay for the device on a continuous or capped monthly rental or a one-time purchase payment. In some of these payment scenarios and until the Equipment is paid in full, ownership of the Equipment may transfer to the beneficiary.

If ownership of the Equipment is transferred to the beneficiary, and the warranty period has expired, it is the beneficiary's responsibility to arrange for any required Equipment service or repair.

ADDITIONAL NOTIFICATIONS FOR CALIFORNIA MEDI-CAL BENEFICIARIES

Medi-Cal may approve rental or purchase of the Equipment on your behalf. If Medi-Cal deems the Equipment a capped rental item, Medi-Cal will pay a monthly rental fee for a period not exceeding ten (10) months and the ownership of Equipment will be transferred to you after the ten (10) months of rental payments by Medi-Cal. ARI provides a limited warranty for the Equipment and will not charge you or Medi-Cal for repair or maintenance while the Equipment is under the warranty and such repair or maintenance is covered by the terms of the warranty. Once the ownership of the Equipment is transferred to you and the warranty period has expired, Medi-Cal may cover the costs of repair or maintenance of the Equipment. However, you might be responsible for the costs of repair or maintenance if Medi-Cal does not authorize such reimbursement.

ADDITIONAL NOTIFICATIONS FOR RESIDENTS OF MAINE

The person signing this authorization may receive a copy of this authorization.

A patient may refuse authorization to disclose some or all health care information, but that refusal may result in improper diagnosis or treatment, or denial of coverage of a claim for health benefits or other insurance. This authorization may be revoked at any time, subject to the right of the person acting in reliance on the authorization to use such revocation as the basis for denial of coverage.

ADDITIONAL NOTIFICATIONS FOR RESIDENTS OF RHODE ISLAND

The person signing this authorization may receive a copy of this authorization.

Consent may be withdrawn at any time except where an authorization is executed in connection with a claim for benefits, and if so, the authorization is valid for the duration of the claim.

PLEASE FAX THE FRONT OF THIS FORM TO

1-866-643-5787 or email to: Patient_Training_Paperwork@Baxter.com

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