Health Aid of Ohio Client Information Checklist

5230 Hauserman Rd Parma, OH 44130 Monday – Friday 8:30-5:00 or by appt. 800-762-5438 3825 Paragon Dr Columbus, OH 43228

First Name:	**Last Name:**	**DOB:**
Address:		**City/State/Zip**
Phone #:	**Email:**	
Insurance Provider:	**Insurance ID #:**	**Group #:**

Assignment of Benefits and Information Release
I request that payment of authorized Medicare, Medicaid, or private insurance benefits be made to Health Aid of Ohio (herein after referred to as "HAO") for any covered services furnished to me by HAO. I authorize any holder of medical information about me to release to CMS and its agents, or to any private insurance company and information needed to determine these benefits or the benefits payable to related service. I authorize release of my clinical records to HAO. These entities may also make copies of these records. I UNDERSTAND THAT I HAVE THE RIGHT TO REFUSE THE RELEASE OF MY RECORDS AND THAT I AM WAIVING THIS RIGHT BY SIGNING THIS CONSENT. I understand that I may revoke this consent by sending written notice to HAO. Such revocation shall have prospective effect only. I further authorize HAO to release this information to accrediting organizations for the purpose of compliance requirements. Additionally I authorize HAO to obtain and review my personal medical records that are held by other agencies for the purpose of submitting claims to my insurance.

Financial Responsibility
The undersigned agrees, where he/she signs as patient, agent, guardian, spouse or representative, that in consideration of the services to be rendered to the patient, the hereby individual guarantees and obligates himself/herself to pay the account with HAO in full. I understand that Medicare, Medicaid and other insurers have guidelines (other than a physician's prescription), that must be met to determine medical necessity in order to make payment.

Insurance Changes
I understand HAO verifies my insurance policies presented to them upon accepting HAO as my Durable Medical Equipment Supplier. The information provided during an insurance verification is never a guarantee of benefits. I know that I am ultimately responsible for knowing my insurance benefits. I do hereby agree to pay any claim for goods or services not covered or denied for any reason by insurance since the date of delivery. I also understand that I am responsible for any co-pay or deductible amounts after claims are paid by said insurance. The undersigned agrees that if the rental or loaner equipment is lost, stolen or damaged, they will pay HAO the cost of replacement or repair of the equipment. I understand that if I have a change in insurance coverage during the rental or purchase process for the services provided by Health Aid of Ohio, my insurance claim will be denied and I will be responsible for the full amount of the charges.

Repairs/Service After Delivery
Health Aid repairs all of the equipment that is provided. Repairs can be scheduled during regular business hours (Mon-Fri, 8:30 am – 5:00 pm) by calling 216-252-3900 or 800-762-5438. Emergency service is available for life sustaining equipment 24 hours a day, 365 days a year by calling the number listed above and selecting the after hours option. *Non-emergency service* is also available after business hours for an additional fee.

Medicare Equipment Warranty Information
Every product sold or rented by our company carries a 1-year manufacturer's warranty. Health Aid of Ohio will notify all Medicare beneficiaries of the warranty coverage, and we will honor all warranties under applicable law. Health Aid of Ohio will repair or replace Medicare-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 on the product I have received.

**Signature: _____

Email/ Texting Waiver
By initialing, I agree to receive text messages and unencrypted emails from HAO to the phone number and email address I have provided. I understand that I am not required to provide my consent as a condition of purchasing any goods or services.

Return Policy
Standard Equipment may be returned within 30 days if unused and accompanied with a receipt. Unused bathroom equipment, in the original packaging, may be returned within 7 days when accompanied with a receipt. Health Aid of Ohio will not accept returned merchandise if worn next to the skin, used for sanitary or hygienic purposes, or if it is disposable. Compression garments, lift chairs, bracing, breast pumps, custom wheelchairs and accessibility product sales are final and these items are not returnable. No exceptions will be made.
Custom equipment – A deposit of 50% is required upon the order of custom items. Custom items may not be returned. I understand that the device or equipment being ordered on my behalf is considered custom-made and that it can't be returned. I agree to accept responsibility for the payment of such fees if the device is unable to be delivered due to my death, cancellation of the order by me, or change in my condition such that the device is no longer medically necessary or appropriate.

Durable Medical Equipment History
Do you or have you possessed any durable medical equipment including but not limited to a cane, walker, crutches, commode, patient lift, hospital bed, specialized mattress, manual or power wheelchair, scooter, special cushion or customized seating?
Date Received: _____ Date Returned: _____ Name of Provider: _____ Funding Source: _____
PLEASE PROVIDE ANY FACTORS THAT MAY SUBSTANTIATE REPLACEMENT OF EXISTING EQUIPMENT:

State of Ohio Sales and Use Tax Blanket Exemption Certificate (prescribed by Tax Commissioner and Rule)
The purchaser hereby claims exception or exemption on all purchases of tangible personal property and selected services from HAO and certifies that this claim is based on purchaser's proposed use of the items or services. The purchaser certifies that the item or service aids in human perambulation or is a hospital bed, wheelchair, supporting device, device used to lift wheelchairs into motor vehicles and/or a device used to supplement impaired functions of the human body.

Signature: _____ Date: _____

The Patient or Caregiver has provided a return demonstration of equipment **Initials: _____**

By signing below, I am attesting that a representative of Health Aid of Ohio has provided the following or made available via www.healthaidofohio.com

- Education regarding the safe operation and maintenance of the equipment, materials and safety precautions.
- The hours of operation and who to contact after hours, for repairs or follow up care and in an emergency
- Medicare Supplier Standards and Customer Rights and Responsibilities (website)
- Welcome booklet including a mission statement and information regarding the Perception of Care Process, Informed Consent and Advance Directives
- HIPAA Privacy Rules/Consent Form (website)
- Warranty Information (included)
- Medicare Capped Rental Notification (included

I ACKNOWLEDGE AND UNDERSTAND THE ENTIRE CONTENTS OF THIS DOCUMENT.

Signature of Customer or Customer Representative	**Date**