SDS Medical Supplies
PATIENT NOTES

PATIENT: _____ ACCOUNT NUMBER: _____

ACHCU

SDS Medical Supplies Inc.| 2375 Wall Street SE, Suite 240 Rm 50, Conyers, GA 30013
Office: (770) 285-4104 | Fax: (770) 285-4152 | Monday-Friday 10:00am to 4:00pm

SDS Medical Supplies
PATIENT INTAKE FORM

Referral Source: _____

Patient Information
Last Name_____ Full First Name_____
Address_____
City_____State_____Zip_____
Phone: _____
Gender: ❑ Male ❑ Female Date of Birth:_____ SSN:_____

Ordering/Prescribing Physician_____ License #_____
Address_____Phone #_____

Follow Up Physician_____License #_____
Address_____ Phone #_____

Related Diagnoses for Service(s) Provided _____
_____

Patient Height: _____ Patient: Weight:_____

Emergency Contact Person_____
Address_____ Phone #_____

Next of Kin/Legal Guardian_____ Phone #_____

Insurance Coverage
#1_____Policy #_____
Address_____Phone #_____
Name of Insured: _____ Date of Birth: _____

#2_____Policy #_____
Address_____Phone #_____
Name of Insured: _____ Date of Birth: _____

Service Begin Date_____

Patient Currently Hospitalized? ❑ Yes ❑ No If Yes, Name of Hospital_____
Phone #:_____Room #_____ Discharge Date_____

Name(s) of other home health providers visiting patient:_____

Equipment / Services Needed:

Person Taking Referral: _____ Date received:_____

Patient Contacted: Date:_____Time:_____ Expected Delivery Date:_____Time:_____

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SDS Medical Supplies
PATIENT SERVICE AGREEMENT

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

_____ (Initials) I acknowledge that I have been advised of my financial responsibilities to SDS Medical Supplies

Returned Goods: I understand that, due to Federal and State 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. SDS Medical Supplies 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.

Patient Handouts: I acknowledge that I have received a copy of the Patient Handouts which contains Patient Rights and Responsibilities, Supplier Standards, Home Safety Information, HIPAA Privacy Standards, Emergency Planning, and Advance Directive Information. I acknowledge that I have received company marketing material and information on the company's scope of services. 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 SDS Medical Supplies with a copy of such document.

Complaint 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 (770) 285-4104 and speak to customer services. 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 Medicare at 1-800-MEDICARE, the Accreditation Commission for Health Care (ACHC) at 919-785-1214 and/or Georgia Board of Pharmacy at https://gbp.georgia.gov/webform/georgia-professional-licensure-complaint-form.

Patient: _____ Date: _____

Witness: _____ Date: _____

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SDS Medical Supplies
PATIENT DELIVERY TICKET

PATIENT _____ PHONE _____

☐ PICKED UP AT COMPANY ☐ DELIVER TO PATIENT'S HOME

QTY	DESCRIPTION	SERIAL NUMBER or LOT NUMBER	RENT	SALE	CHARGES

I acknowledge that I have been advised of my financial responsibilities to SDS Medical Supplies Initials:_____

❑ Check if equipment was sold to the patient and that the warranty card(s) is / are given to the patient.

I acknowledge training in the use of equipment and products provided and the performance of the Assessment and Plan of Service on the date noted.

_____ _____ _____

Patient Signature Date Staff Member

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SDS Medical Supplies
PATIENT VISIT REPORT - EQUIPMENT MAINTENANCE

Patient: _____ Date: _____

Phone: _____ Any Hospitalizations since last visit? ❑ Yes ❑ No _____

Any changes in Insurance or Physician since last visit? ❑ Yes ❑ No _____

EQUIPMENT INFORMATION					
Manufacturer	Model#	Serial #	Hours (if applicable)	Settings (if applicable)	Maintenance Performed

EQUIPMENT EXCHANGES AND D/C'S

Old Unit _____ SN _____ New Unit _____ SN _____ Reason _____
Old Unit _____ SN _____ New Unit _____ SN _____ Reason _____

D/C'd Unit _____ SN _____ Reason _____
D/C'd Unit _____ SN _____ Reason _____

SUPPLIES DISPENSED

PLAN OF SERVICE UPDATE

Outcomes being met? ❑ Yes ❑ No (If No, document education provided below and document any concerns)

Equipment functional? ❑ Yes ❑ No (If No, was it ❑ Repaired? or ❑ Replaced?)

Patient reeducated on the following?

❑ Use of Equipment ❑ Doctor's Prescription
❑ Emergency Preparedness ❑ Troubleshooting Equipment ❑ Fire / Electrical / Home Safety
❑ When to call for services ❑ Changes in Doctor's Orders ❑ Use of Back up Equipment

Any other safety or health hazards? ❑ Yes ❑ No (If Yes, document concerns)

_____

_____

I acknowledge performance of the Patient Visit and Plan of Service update on the date noted:

_____ _____ _____
Patient Date Technician/Therapist

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SDS Medical Supplies

PATIENT VISIT REPORT - EQUIPMENT PICK UP

Patient: _____ Date: _____

Phone: _____ Any Hospitalizations since last visit? ❑ Yes ❑ No _____

Any changes in Insurance or Physician since last visit? ❑ Yes ❑ No _____

EQUIPMENT PICKED UP				
Manufacturer	Model#	Serial #	Hours (if applicable)	Reason

PLAN OF SERVICE UPDATE

❑ No Company Owned Equipment Remains in the Patient's Home

Evaluate Plan of Service and update as needed below if any company equipment remains in the home

Outcomes being met? ❑ Yes ❑ No (If No, document education provided below and document any concerns)

Equipment functional? ❑ Yes ❑ No (If No, was it ❑ Repaired? or ❑ Replaced?)

Patient reeducated on the following?

❑ Use of Equipment ❑ Doctor's Prescription
❑ Emergency Preparedness ❑ Troubleshooting Equipment ❑ Fire / Electrical / Home Safety
❑ When to call for services ❑ Changes in Doctor's Orders ❑ Use of Back up Equipment

Any other safety or health hazards? ❑ Yes ❑ No (If Yes, document concerns)

_____

_____

I acknowledge the equipment listed above was picked up and the Plan of Service was updated on the date noted:

_____	_____	_____
Patient	Date	Technician/Therapist

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SDS Medical Supplies
EQUIPMENT MANAGEMENT ADMISSION ASSESSMENT AND PLAN OF SERVICE

Patient: _____ Date: _____

Phone: _____

EQUIPMENT DISPENSED				
Manufacturer	Model#	Serial #	Hours (if applicable)	Settings (if applicable)

SUPPLIES DISPENSED

HOME ASSESSMENT-ENVIRONMENTAL / SAFETY

☐ CHECK IF PICKED UP AT COMPANY (Do not complete the home assessment if picked up at the company)

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? _____

DOCUMENT ANY OTHER SAFETY OR HEALTH HAZARDS CONCERNS AND INFORMATION GIVEN THE PATIENT: _____

PLAN OF SERVICE

Identified Needs/Problems:

- The patient is or may be unfamiliar with use and maintenance of the home medical equipment dispensed.
- The patient may be uncertain of home safety.
- The patient may be required to troubleshoot the equipment or use back-up equipment.
- The patient may require follow-up services.

Expected Outcomes:

- The patient will be provided prescribed equipment to comply with the physician's prescription.
- The patient will use the home medical equipment as prescribed by the physician.
- The patient will use and maintain home medical equipment in a safe/proper manner.
- The patient will adhere to home safety guidelines.
- The patient will be able to troubleshoot any equipment problems and/or use back-up system.
- The patient 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 patient rights and responsibilities, supplier standards, home safety, HIPAA Privacy standards, emergency planning, scope of service / marketing info 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

❑ Check if equipment was sold to the patient and that the warranty card(s) is / are given to the patient. Mark N/A if no sale items are provided.

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.

Patient Signature	Date	Staff Member

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SDS Medical Supplies
FITTER SERVICES: ADMISSION ASSESSMENT AND PLAN OF SERVICE

Patient: _____ Date: _____

Phone: _____

PRODUCTS AND SUPPLIES DISPENSED				
Manufacturer	Model or Item #	Description	Number Dispensed	Lot # (if applicable)

PATIENT ASSESSMENT

Measurements and sizing of products _____

Allergies to materials _____

Skin Condition _____

Previous use of an orthoses/prostheses _____

Customization of products _____

Recommendations to the patient _____

PLAN OF SERVICE

Identified Needs/Problems:

- The patient is or may be unfamiliar with use of the Fitter Service Product(s).
- The patient is or may be unfamiliar with Fitter Service Products that are available.
- The patient may require follow-up services.

Expected Outcomes:

- Check those that apply: ❑ reduce pain ❑ increase comfort ❑ enhance function and independence ❑ provide joint stability ❑ prevent deformity ❑ increase range of motion ❑ address cosmetic issues ❑promote healing
- The patient will be provided the Fitter Service Product(s) to comply with the physician's prescription (if required).
- The patient will use the Fitter Service Product(s) as prescribed by the physician.
- The patient will use Fitter Service Product(s) in a safe/proper manner.
- The patient will communicate to the staff any Fitter Service Product(s) problems.
- The patient will know how to obtain follow-up services as needed.

Services/Actions to be Provided:

- Assess the patient and fit the Product(s).
- Provide training in use of the Fitter Service Product(s).
- Provide training and written handout in patient rights and responsibilities, supplier standards, home safety, HIPAA Privacy standards, emergency planning and provide financial responsibilities.
- Demonstrate cleaning and care of the products provided.
- Provide written instructions for use of the Fitter Service Product(s).
- Provide written instructions for obtaining follow-up services.

❑ Check that the warranty information was given to the patient.

I acknowledge training in the use of the products provided and the performance of the Fitter Services Admission Assessment and Plan of Service on the date noted.

Patient Signature	Date	Fitter Service Technician Signature

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SDS Medical Supplies

MEDICARE CAPPED RENTAL AND INEXPENSIVE OR ROUTINELY PURCHASED ITEMS NOTIFICATION

I received instructions and understand that Medicare defines the _____ that I received as being either a capped rental or an inexpensive or routinely purchased item.

FOR CAPPED RENTAL ITEMS:

Medicare will pay a monthly rental fee for a period not to exceed 13 months, after which ownership of the equipment is transferred to the Medicare beneficiary.

After ownership of the equipment is transferred to the Medicare beneficiary, it is the beneficiary's responsibility to arrange for any required equipment service or repair.

Examples of this type of equipment include: Hospital beds, wheelchairs, alternating pressure pads, air-fluidized beds, nebulizers, suction pumps, continuous airway pressure (CPAP) devices, patient lifts, and trapeze bars.

FOR INEXPENSIVE OR ROUTINELY PURCHASED ITEMS:

Equipment in this category can be purchased or rented; however, the total amount paid for monthly rentals cannot exceed the fee schedule purchase amount.

Examples of this type of equipment include: Canes, walkers, crutches, commode chairs, low pressure and positioning equalization pads, home blood glucose monitors, seat lift mechanisms, pneumatic compressors (lymphedema pumps), bed side rails, and traction equipment.

I select the:

- ❑ Purchase Option
- ❑ Rental Option

_____ _____

Beneficiary Signature Date

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SDS Medical Supplies
EQUIPMENT WARRANTY INFORMATION FORM

Every product sold or rented by our company carries a 1-year manufacturer's warranty. SDS Medical Supplies will notify all Medicare beneficiaries of the warranty coverage, and we will honor all warranties under applicable law.

SDS Medical Supplies will repair or replace, free of charge, 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.

Beneficiary's Signature_____Date_____

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SDS Medical Supplies
PATIENT SATISFACTION SURVEY

Date:_____

Dear Patient,

It is our desire to provide you with the best quality services available. In order to help us maintain our high standards, please take a few moments to tell us how we are doing. Please complete this form and mail it back to us. Thank you.

Was your equipment (and supplies if applicable) delivered on time?	❑ YES	❑ NO
Was the equipment (and supplies if applicable) delivered / dispensed accurately?	❑ YES	❑ NO
Was the training and consultations effective in educating you or your caregiver on your equipment (and supplies if applicable)?	❑ YES	❑ NO
Was the educational materials and instructions provided adequate to educate you or your caregiver on the product(s) provided?	❑ YES	❑ NO
Was the company staff courteous and helpful?	❑ YES	❑ NO
Was your financial responsibilities explained to you?	❑ YES	❑ NO
Did you receive advice or help when requested?	❑ YES	❑ NO
Did the services provided make a positive impact on the outcome of your care?	❑ YES	❑ NO
Would you recommend our services to friends and family?	❑ YES	❑ NO
Did the services provided meet your needs and expectations?	❑ YES	❑ NO

COMMENTS (OPTIONAL)

Signature (optional)_____

Form Revised: 06/11/2019

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