We extend a warm welcome to you, your family, and caregivers.

Based on the orders obtained from your doctor, we will provide your medical treatment. Our team understands the importance of providing infusion therapy and specialty pharmaceutical services that enhance independence and daily activities. Our commitment is to provide quality care, treatments, and services in a respectful and least intrusive manner.

ReinHealth is an innovative healthcare services provider with the ability to not only provide specialty pharmacy services, but also infusion therapy services and infectious disease specialty consults for the full continuum of care. **We do not** discriminate against any person because of race, color, sex, religion, national origin, or age and comply with all federal, state, and local laws and regulations.

Our Performance Improvement Team constantly monitors the quality of services. Patients always retain the right to clearly voice their dissatisfaction, concern, or content with services rendered without fear of reprisal. We are responsive to customers and any questions, comments, compliments or concerns you may have. We welcome your feedback. E-mail to: info@reinhc.com.

If you have additional questions or need assistance, please call ReinHealth at **(972) 661-CARE (2273)** and one of our friendly staff members will be glad to assist you. We have on-call 24-hour access to staff members.

For life-threatening emergency situations please call 911.

*Sincerely,*

*ReinHealth*

---

**Hours of Operation**

**Monday - Friday: 9:00 AM to 5:00 PM**

**Saturday - Sunday: CLOSED**

**Lewisville**
2790 Lake Vista Dr.
Lewisville, TX 75067
972-661-2273
MON–FRI 9am to 5pm

**Dallas**
11970 North Central Expwy, Ste 630
Dallas, TX 75243
972-661-2273
MON–FRI 9am to 5pm

**Plano**
5425 Spring Creek Pkwy, Ste 135
Plano, TX 75024
972-661-2273
MON–FRI 9am to 5pm

**Rowlett**
6800 Heritage Pkwy, Ste 105
Rowlett, TX 75087
972-661-2273
MON–FRI 9am to 5pm

SAT–SUN 9am to noon
# REGISTRATION FORM

*(Please Print)*

*Americare Medical Partners, PLLC is a registered corporation in the state of Texas, hereinafter referred to as Rein Health.*

## PATIENT INFORMATION

<table>
<thead>
<tr>
<th>Patient’s last name:</th>
<th>First:</th>
<th>Middle:</th>
<th>Date of Birth:</th>
<th>Gender:</th>
</tr>
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<tbody>
<tr>
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<td><em><strong><strong>/</strong></strong></em>/_____</td>
<td>[ ] Male [ ] Female</td>
</tr>
<tr>
<td>Marital Status:</td>
<td>Social Security #:</td>
<td>Former Name:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Married □ Single</td>
<td><em><strong><strong><strong>.-</strong>_____<strong>-</strong></strong></strong></em>__</td>
<td></td>
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<tr>
<td>□ Divorced □ Widowed</td>
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<table>
<thead>
<tr>
<th>Street Address:</th>
<th>City:</th>
<th>State:</th>
<th>Zip Code:</th>
<th>Home Phone:</th>
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<tr>
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<td>(________ ) ( ________) - ________</td>
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<table>
<thead>
<tr>
<th>Email:</th>
<th>Cell Phone:</th>
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<td>(________ ) ( ________) - ________</td>
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<thead>
<tr>
<th>Occupation:</th>
<th>Employer:</th>
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<thead>
<tr>
<th>Referring Physician:</th>
<th>Primary Care Physician:</th>
<th>Pharmacy:</th>
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<tr>
<th>Referring Physician Phone #:</th>
<th>Primary Care Physician Phone #:</th>
<th>Pharmacy Phone #:</th>
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<tbody>
<tr>
<td>(________ ) ________ - ________</td>
<td>(________ ) ________ - ________</td>
<td>(________ ) ________ - ________</td>
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</tbody>
</table>

## INSURANCE INFORMATION

<table>
<thead>
<tr>
<th>Primary Insured Name:</th>
<th>Date of Birth:</th>
<th>Social Security #:</th>
<th>Primary Insured Phone#:</th>
</tr>
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<tbody>
<tr>
<td></td>
<td><em><strong><strong>/</strong></strong></em>/_____</td>
<td><em><strong><strong><strong>.-</strong>_____<strong>-</strong></strong></strong></em>__</td>
<td>(________ ) ( ________) - ________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Relationship to Insured:</th>
<th>Primary Insured Address:</th>
<th>City:</th>
<th>State:</th>
<th>Zip Code:</th>
</tr>
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<thead>
<tr>
<th>Phone # (For Providers):</th>
<th>Phone # (For Providers):</th>
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</table>

<table>
<thead>
<tr>
<th>Member, Subscriber, or Policy #:</th>
<th>Group #:</th>
</tr>
</thead>
<tbody>
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</tr>
</tbody>
</table>

## EMERGENCY CONTACT

<table>
<thead>
<tr>
<th>Name of local friend or relative:</th>
<th>Relationship to patient:</th>
<th>Home Phone:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>(________ ) ( ________) - ________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cell Phone:</th>
</tr>
</thead>
<tbody>
<tr>
<td>(________ ) ( ________) - ________</td>
</tr>
</tbody>
</table>

**PATIENT / GUARANTOR SIGNATURE** ___________________________ **DATE:** ______________

Guarantor Name: *(Please Print)* ___________________________
HEALTH HISTORY QUESTIONNAIRE

Patient Name (Print):______________________________    Date of Birth:_________________________

### REASON FOR YOUR VISIT TODAY

What is your current illness or symptoms?

When did your illness or symptoms start?

Have you taken anything to help relieve these symptoms?

Have you been seen by another physician regarding this illness?  □ Yes, physician name ________________  □ No

Do you have any pain?  □ Yes  □ No  If yes, on a scale of 1 to 10, what is your pain level?

The pain is  □ Throbbing  □ Sharp  □ Dull  □ Constant  □ Other _________________

### PAST MEDICAL HISTORY

(Please check all that apply)

□ Cancer  □ High blood pressure  □ Liver Disease  □ Rheumatoid Arthritis

□ Diabetes  □ Anemia  □ Kidney Disease  □ Tuberculosis (TB)

□ Heart Disease  □ Seizures  □ Asthma  □ STD (Type:__________________________)

□ Thyroid Disease  □ Lung Disease  □ Stomach Ulcer  □ Other __________________________

### FAMILY MEDICAL HISTORY

□ Cancer  □ High blood pressure  □ Lung Disease

□ Diabetes  □ Liver Disease  □ Kidney Disease

□ Heart Disease  □ Thyroid Disease  □ Other __________________________

### SURGERIES/HOSPITALIZATIONS

<table>
<thead>
<tr>
<th>Year</th>
<th>Reason</th>
<th>Complications</th>
<th>Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ex: 2016</td>
<td>Hip replacement</td>
<td>Infected incision</td>
<td>Medical Center of Plano</td>
</tr>
</tbody>
</table>

### HEALTH HABITS AND PERSONAL SAFETY

| Exercise                      | □ Inactive  □ Mild exercise  □ Occasional vigorous exercise  □ Regular vigorous exercise |
|-------------------------------|-----------------|--------------------------|-------------------------------|
| Caffeine                      | □ None  □ Coffee  □ Tea  □ Cola  | # of cups/cans per day       |
| Alcohol                       | □ Yes  □ No     |                          |                               |

Do you drink alcohol or have you in the past?  □ Yes  □ No

If yes, what kind?  □ Wine  □ Beer  □ Hard Liquor  How many drinks per week?  □ 1-2  □ 3-4  □ 4+

Do you use tobacco or have you in the past?  □ Yes  □ No

□ Cigarettes/Pipe/Cigars- #/day ______  □ Smokeless Tobacco  # of years_____  Year quit _________

<table>
<thead>
<tr>
<th>Drugs</th>
<th>□ Yes  □ No</th>
<th></th>
<th></th>
</tr>
</thead>
</table>

Do you currently use recreational or street drugs or have you in the past?  □ Yes  □ No

If yes, what kind?
**IMMUNIZATION HISTORY:**

<table>
<thead>
<tr>
<th>Date: Month/Year</th>
<th>Date: Month/Year</th>
<th>Date: Month/Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Influenza</td>
<td>☐ Pneumonia</td>
<td>☐ MMR</td>
</tr>
<tr>
<td>☐ Hepatitis B</td>
<td>☐ TDAP</td>
<td>☐ HPV</td>
</tr>
<tr>
<td>☐ TB Skin Test</td>
<td>☐ Meningitis</td>
<td>☐ Other</td>
</tr>
</tbody>
</table>

**ALLERGIES**

<table>
<thead>
<tr>
<th>Name of medication or other allergen</th>
<th>Type of Reaction (rash, nausea, fever, swelling, etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example: Latex</td>
<td>Rash, swelling</td>
</tr>
</tbody>
</table>
Medical Directive Questionnaire

Patient Name (Printed)_________________________ Date of Birth:__________________________

Do you have a DO NOT RESUSCITATE (DNR) order in place?  □ No  □ Yes
If yes can you provide a copy?  □ No  □ Yes

Do have a Medical Directive?  □ No  □ Yes
If yes can you provide a copy?  □ No  □ Yes

Do you have a Surrogate Decision Maker?  □ No  □ Yes
If yes, please provide:  Name: ______________________________________________
                       Phone: _____________________________________________

If a true life-threatening event is present, staff shall activate the emergency medical system (EMS) by dialing 9-1-1 (unless contraindicated by an advance directive) and remain until help arrives. PERSONNEL ARE NOT TO ACTIVATE THE EMS SYSTEM IF DOING SO GOES AGAINST THE ADVANCE DIRECTIVES OF A PATIENT THAT IS ON FILE OR CURRENTLY PRESENT AT THE PLACE OF INCIDENT.

PATIENT / GUARANTOR SIGNATURE_________________________________________ DATE:______________

Guarantor Name: (Please Print) ________________________________________________
Patient Choice Statement
(To be completed for all new patients/guardians)

Patient Name: ________________________________

I the undersigned, patient/guardian understand that it is my right to select the Home Infusion / Pharmacy provider of my choice. I have selected Rein Health (AmeriCare Infusion Centers, LLC) free of any undue pressure or solicitation by any employee of Rein Health (AmeriCare Infusion Centers, LLC) and further declare that my receipt of Home Infusion Therapy, Ambulatory Infusion, or other Pharmacy Services from Rein Health (AmeriCare Infusion Centers, LLC) is by choice. I have been advised by a Rein Health (AmeriCare Infusion Centers, LLC) representative that if for any reason I wish to change services to another home medical equipment/pharmacy Provider, it is my right to do so.

I am making this request of my own free will and have not been coerced, solicited, or pressured to do so by any employee of Rein Health (AmeriCare Infusion Centers, LLC). I hereby authorize the release of any requested documents to Rein Health (AmeriCare Infusion Centers, LLC), relating to prior services that the above named provider rendered to me.

______________________________          ____________________
Signature of Patient/Guardian          Date

______________________________          ____________________
Patient Name (Printed)                  DOB

______________________________          ____________________
Signature of Rein Health Representative Date
FINANCIAL RESPONSIBILITY AGREEMENT

Patient Name (Print):________________________________________ Date of Birth:_____________________

I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance for my visits. This includes any medical services or visit, preventative exam or physical, lab testing, x-ray, EKG, and any other screening service or diagnostic testing ordered by the physician or the physician's staff.

I understand and agree it is my responsibility and not the responsibility of the physician or the physicians' staff to know if my insurance will pay for any of the medical service I receive.

I understand and agree it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out-of-network amounts, usual and customary limit, or any other type of benefit limitation for the medical services I receive.

I understand and agree it is my responsibility to know if the physician or provider I am seeing is a contracted in-network provider recognized by my insurance company or plan. If my insurance company or plan does not recognize the physician or provider I am seeing, it may result in claims being denied or higher out of pocket expense to me. I understand this and agree to be financially responsible for all charges.

I understand and agree it is my responsibility to know if my insurance requires a referral from my PCP (primary care physician). If a referral is required and I do not request it, it may result in claims being denied. I understand this and agree to be financially responsible and make full payment.

PATIENT / GUARANTOR SIGNATURE________________________________________ DATE:_____________________

Guarantor Name: (Please Print)________________________________________
Patient’s Name (Printed): ___________________________ Date of birth: ________________

Assignment of Insurance Benefits:  
I hereby authorize direct payment of my insurance benefits to ReinHealth or the physician individually for services rendered to me, or my dependents, by the physician or those under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive have a covered benefit. I understand and agree that I will be responsible for any co-pay or balance that ReinHealth is unable to collect from my insurance carrier for whatever reason.

Medicare / Medicaid / Champus Insurance Benefits:  
I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my, or my dependent’s records that these programs may request. I hereby direct that payment of my, or my dependent’s authorized benefits be made directly to Rein Health or the physician on my behalf.

Authorized to Release Non-Public Personal Information:  
I certify that I have read and been offered a copy of the ReinHealth “HIPAA Notice of Privacy Practices”. I hereby authorize ReinHealth or the physician individually to release any of my or my dependent’s medical or incidental nonpublic personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

As permitted by the Health Insurance Portability and Accountability Act (HIPAA), I understand that my protected health information may be used and disclosed by my physician, office staff, and others outside of these offices who are involved in my care and treatment for the purpose of providing health care services. Although all NPs, RNs and infusion center staff will attempt to conceal written medical information, I understand that other patients or staff in the infusion center may overhear the staff when medical information is provided to me. I further acknowledge that the infusion center is an open treatment area that may be monitored by video surveillance. By signing this page I give my consent to be monitored and recorded by video. By signing this page, I acknowledge that I have read and fully understand the above statement.

Authorization to Mail, Call, Text or E-Mail:  
I certify that I understand the privacy risks of the mail, phone calls, text messages and e-mail. I hereby authorize a ReinHealth representative or my physician to mail, call, or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and diagnostic test results. I understand that I have the right to rescind this authorization at any time by notifying ReinHealth to that effect in writing. I understand that e-mail and/or text message is not a confidential method of communication and is subject to certain risks. I understand and acknowledge that ReinHealth cannot guarantee the privacy, security or confidentiality of information transmitted via e-mail or text. I understand that I may revoke my consent at any time by advising ReinHealth in writing.

Please Check Your Response to the Following:

ReinHealth personnel may leave messages on a voicemail at: ☐ Home Number ☐ Cell Number ☐ Work Number

ReinHealth personnel may send e-mails regarding my healthcare to the following address: ______________________________

I authorize ReinHealth personnel to discuss my healthcare with the following people:

Name_________________________Phone_________________________Relationship_________________________

Name_________________________Phone_________________________Relationship_________________________

You must inform us in writing if you wish to change the manner in which this office communicates with you.

Lab/X-Ray/Diagnostic Services:  
I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balances due for these services if they are not reimbursed by my insurance for whatever reason.

Hepatitis B Virus Consent For Treatment  
For patients on the following medications: Actemra, Cimzia, Orecencia, Remicade, Rituxan, Simponi Aria: If I have not had a Hepatitis B Virus (HBV) vaccination or I refuse such vaccination, I understand that due to my exposure to potentially infectious material, I may be at risk of acquiring HBV. I understand that by not obtaining this vaccine, I continue to be at an increased risk of acquiring HBV, a serious disease.

Pregnancy and Breastfeeding Consent for Treatment  
For females: Please check (1) of the following:

☐ I am not pregnant now and have no reason to suspect that I am pregnant. I am aware of the potential risks, known and unknown, to the fetus if I become pregnant during treatment including miscarriage or congenital deformity. If I should become pregnant, I will notify the clinical staff immediately.

☐ I am pregnant, will continue treatment and am aware of the potential risks, known and unknown, to the fetus including miscarriage or congenital deformity.

☐ I am breastfeeding and will continue breastfeeding while receiving treatment. I am aware of the potential risks, known and unknown to my breastfeeding child while receiving treatment.

Consent To Treat:  
I hereby consent to evaluation, testing, and treatment as directed by my ReinHealth physician or those under his/her supervision.

PATIENT / GUARANTOR SIGNATURE: ___________________________ DATE: __________________________

Guarantor Name: (Please Print) ___________________________
Receipt of Privacy Policy (HIPPA)

I understand that as a condition to my receiving services *Rein Health (AmeriCare Infusion Centers, LLC)* may use or disclose my personally identified health information for services, to obtain payment for the services provided, and as necessary for the operations of this office. These uses and disclosures are more fully explained in the Privacy Notice that has been provided to me, and which I have had the opportunity to review.

I understand that the privacy practices described in the Privacy Notice may change over time, and that I have a right to obtain any revised Privacy Notice by contacting company representative to make such a request.

I also understand that I have the right to request *Rein Health (AmeriCare Infusion Centers, LLC)* to restrict how my health information is used or disclosed.

*Rein Health (AmeriCare Infusion Centers, LLC)* does not have to agree to my request for the restriction, but, if *Rein Health (AmeriCare Infusion Centers, LLC)* does agree, *Rein Health (AmeriCare Infusion Centers, LLC)* is bound to abide by the restriction as agreed. Finally, I understand that I have the right to revoke/withdraw this consent, in writing, at any time. My revocation/withdrawal will be effective except to the extent that *Rein Health (AmeriCare Infusion Centers, LLC)* has taken action in reliance on my consent for use or disclosure of my health information. Provision of future services may be withdrawn if I withdraw my consent.

________________________________    _____________________
Patient Name  Date

SIGN HERE

________________________________    _____________________
Patient Name (Printed)  DOB
DMEPOS suppliers are prohibited from sharing a practice location with certain other Medicare providers and suppliers.

1. A supplier must be in compliance with all applicable Federal and State licensure and regulatory requirements and cannot contract with an individual or entity to provide licensed services.

2. A supplier must provide complete and accurate information on the DMEPOS supplier application. Changes to this information must be reported to the National Supplier Clearinghouse within 30 days.

3. An authorized individual (one whose signature is binding) must sign the application for billing privileges.

4. A supplier must fill orders from its own inventory, or must contract with other companies for the purchase of items necessary to fill the order. A supplier may not contract with any entity that is currently excluded from the Medicare program, any State health care programs, or from any other Federal procurement or non-procurement programs.

5. A supplier must advise beneficiaries that they may rent or purchase inexpensive or routinely purchased durable medical equipment, and of the purchase option for capped rental equipment.

6. A supplier must notify beneficiaries of warranty coverage and honor all warranties under applicable State law, and repair or replace free of charge Medicare covered items that are under warranty.

7. A supplier must maintain a physical facility on an appropriate site. This standard requires that the location is accessible to the public and staffed during posted hours of business. The location must be at least 200 square feet and contain space for storing records.

8. A supplier must permit CMS, or its agents to conduct on-site inspections to ascertain the supplier’s compliance with these standards. The supplier location must be accessible to beneficiaries during regular business hours, and must maintain a visible sign and posted hours of operation.

9. A supplier must maintain a primary business telephone listed under the name of the business in a local directory or a toll free number available through directory assistance. The exclusive use of a beeper, answering machine, answering service or cell phone during posted business hours is prohibited.

10. A supplier must have comprehensive liability insurance in the amount of at least $300,000 that covers both the supplier’s place of business and all customers and employees of the supplier. If the supplier manufactures its own items, this insurance must also cover product liability and completed operations.

11. A supplier must agree not to initiate telephone contact with beneficiaries, with a few exceptions allowed. This standard prohibits suppliers from contacting a Medicare beneficiary based on a physician’s oral order unless an exception applies.

12. A supplier is responsible for delivery and must instruct beneficiaries on use of Medicare covered items, and maintain proof of delivery.

13. A supplier must answer questions and respond to complaints of beneficiaries, and maintain documentation of such contacts.

14. A supplier must maintain and replace at no charge or repair directly, or through a service contract with another company, Medicare-covered items it has rented to beneficiaries.

15. A supplier must accept returns of substandard (less than full quality for the particular item) or unsuitable items (inappropriate for the beneficiary at the time it was fitted and rented or sold) from beneficiaries.

16. A supplier must disclose these supplier standards to each beneficiary to whom it supplies a Medicare-covered item.

17. A supplier must disclose to the government any person having ownership, financial, or control interest in the supplier.

18. A supplier must not convey or reassign a supplier number; i.e., the supplier may not sell or allow another entity to use its Medicare billing number.

19. A supplier must have a complaint resolution protocol established to address beneficiary complaints that relate to these standards. A record of these complaints must be maintained at the physical facility.

20. Complaint records must include: the name, address, telephone number and health insurance claim number of the beneficiary, a summary of the complaint, and any actions taken to resolve it.

21. A supplier must agree to furnish CMS any information required by the Medicare statute and implementing regulations.

22. All suppliers must be accredited by a CMS-approved accreditation organization in order to receive and retain a supplier billing number. The accreditation must indicate the specific products and services, for which the supplier is accredited in order for the supplier to receive payment of those specific products and services (except for certain exempt pharmaceuticals).

Implementation Date - October 1, 2009

23. All suppliers must notify their accreditation organization when a new DMEPOS location is opened.

24. All suppliers locations, whether owned or subcontracted, must meet the DMEPOS quality standards and be separately accredited in order to bill Medicare.

25. All suppliers must disclose upon enrollment all products and services, including the addition of new product lines for which they are seeking accreditation.

26. Must meet the surety bond requirements specified in 42 C.F.R. 424.57(c).


28. A supplier must obtain oxygen from a state- licensed oxygen supplier.

29. A supplier must maintain records and follow documentation consistent with provisions provided in 42 C.F.R. 424.516(f).

30. DMEPOS suppliers are prohibited from sharing a practice location with certain other Medicare providers and suppliers.

INSURANCE AND BILLING INFORMATION

The Rein Health (AmeriCare Infusion Centers, Inc) billing department is designed to bill your insurance company for the services you receive from us. If you have coverage from more than one health insurance company, you will be billed as to which company is primary and should be billed first. Since each health insurance policy coverage varies, we suggest you call your insurance company if you have any questions regarding coverage. By filling an insurance claim for you, we hope to make the billing process trouble free. Regardless of insurance coverage, you are ultimately responsible for your bill. If your insurance carrier has questions or requests additional information from you, please respond promptly. If you have any questions regarding the status of your claim, we suggest you contact your insurance company directly. The billing department is ready to answer billing and insurance questions and can be reached at 972-691-CARE (2273).

FOR YOUR INFORMATION

EMERGENCY MANAGEMENT PLAN

Rein Health (AmeriCare Infusion Centers, LLC) shall provide to all patients at time of delivery of all life-sustaining or life-supporting medical equipment a copy of the Certified Emergency Management Plan.

Personnel Responsibilities

All patients and/or caregivers receiving life-sustaining or life-supporting equipment will be instructed and educated about maintaining equipment and supplies and will be supplied with an instruction manual and supply list.

At time of delivery of all life-sustaining or life-supporting equipment a copy of the special needs registry will be presented to the patient and/or caregiver. At time of delivery of all life-sustaining or life-supporting equipment the patient and/or caregiver will be educated on the special needs registry. Including local shelters, things they will need to take, evacuation, etc.

Patients and/or caregivers receiving life-sustaining or life-supporting equipment that are not currently registered with the special needs registry will be given a copy and addressed of AmeriCare Infusion Centers, Inc’s CEMP prior to, during and immediately following an emergency.

Equipment and Supply List

At time of delivery the patient and/or caregiver will be provided with an updated equipment and supply list describing all life-sustaining or life-supporting equipment and supplies that will they will need to take with them to a special needs shelter in their area.

Notification of a Possible Emergency

All Rein Health (AmeriCare Infusion Centers, LLC) personnel will be alerted by the General Manager or the Assistant General Manager of any and all impending emergency situations and the implementation of the CEMP will be activated. All Rein Health (AmeriCare Infusion Centers, LLC) contractors will be notified of the implementation of the CEMP pending any and all emergency situations. All Rein Health (AmeriCare Infusion Centers, LLC) personnel will follow the instructions given by the General Manager or the Assistant General Manager regarding reporting to work in the event of an emergency and the office/facility remains operational.

All patients and/or caregivers receiving any life-sustaining or life-supporting equipment will be notified of the precautionary measures that will be taken, but not limited to, the continuation of the same type and quantity of services to consumers evacuated to special needs shelters, unless the emergency situation is beyond our control. All patients and/or caregivers using any life-sustaining or life-supporting equipment will be provided with a list of alternate phone numbers in the event that the primary notification system should fail. A prioritized list of patients receiving life-sustaining or life-supporting equipment shall be maintained and made available to the county health department and local emergency management agency’s when requested. This list shall indicate the means by which services shall be continued for each patient, whether the patient has life-supporting or life-sustaining equipment, including the specific type of equipment and related supplies.
Evacuation
All patients will receive updated equipment and supplies list to be kept in their residence when life-sustaining or life-supporting equipment is delivered. At time of delivery of all life-sustaining or life-supporting equipment the patient and/or caregiver will be educated on the specific needs registry. Including local shelters, things they will need to take, evacuation, etc. During a mandatory evacuation all Rein Health (AmeriCare Infusion Centers, LLC) personnel will not only educate but shall lend assistance to the patient or caregiver to ensure adequate equipment and supplies are provided.

Rein Health (AmeriCare Infusion Centers, Inc.) shall deliver essential equipment, services and/or referrals to other organizations subject to written agreements including how Rein Health (AmeriCare Infusion Centers, LLC) will continue to provide service to consumers who relocate within or outside the geographic service area.

SCOPE OF SERVICES
AmeriCare Infusion Centers, Inc. will provide patients, caregivers, customers, facilities and referrals with general information concerning our staff and time frame for completing physician orders and delivery times.

- Rein Health (AmeriCare Infusion Centers, LLC) staff will notify patients, caregivers, customers, facilities and referrals when a Service Technician or delivery personnel is expected to deliver or service equipment with an approximate or estimated delivery time.
- Rein Health (AmeriCare Infusion Centers, LLC) staff will also advise patients, caregivers, customers, facilities and referrals of what equipment is to be delivered or serviced and who authorized the order or prescription. Rein Health (AmeriCare Infusion Centers, LLC) provides same day service and delivery on all standard stock items. Specialty items may require up to 3-5 business days. Should delivery of specialized items take any longer than the estimated 3-5 business days the patients, caregivers, customers, facilities and referrals will be notified accordingly.
- Rein Health (AmeriCare Infusion Centers, LLC) service professional will be available to your facility and staff 24-hours each day, seven (7) days a week.
- Rein Health (AmeriCare Infusion Centers, LLC) professional will service patients, caregivers, customers, facilities and referrals on a regular basis.
- Rein Health (AmeriCare Infusion Centers, LLC) will furnish each patient, caregivers, customers, facilities and referrals with complete training of all products, supplies and equipment to ensure proper and safe use by a trained and qualified technician.
- Rein Health (AmeriCare Infusion Centers, LLC) shall provide home safety evaluations and supply each patient with an equipment guide or instruction manual for using each piece of equipment.

STATE ABUSE HOTLINE NUMBER: 1-800-252-5400

Recall Procedure:
In the event of a product recall, Rein Health will promptly notify you and retrieve the product. We will also inform you of the nature of the recall and any steps you may need to take to ensure your safety.

PHARMACY NOTICE:
Written information about this prescription has been provided to you. Please read this information before you take the medication. If you have any questions concerning the prescription, a pharmacist is available during normal business hours to answers these questions, Monday – Friday 9:00 am – 5:00 pm.

Se la presentado a usted, informacion acerca el escrito de esta receta. Porfavor de leer esta informacion antes de tomar el medicamento. Si usted tiene preguntas sobre esta receta, nuestro Farmaceutico esta disponible para contestar sus preguntas durante las horas normal de negocio, Lunes a Viernes de 9:00 am – 5:00 pm.

Phone: 972-661-2273 Fax: 1-866-292-6489

CLINIC NOTICE:
If you have any questions concerning your health care services, a nurse/doctor is available during normal business hours to answer these questions Monday – Friday 9:00 am – 5:00 pm.

Si usted tiene preguntas sobre esta servicios de medida una Enfermera esta disponible para contestar sus preguntas durante las horas normal de negocias, Lunes a Viernes de 9:00 am – 5:00 pm.

Phone: 972-661-2273 Fax: 1-866-292-6489

I have been informed of and understand my rights and responsibilities.

Signature: ___________________________ Date: ___________________________

Patient Name (Print): ___________________________ DOB: ___________________________

Rein Health (AmeriCare Infusion Centers, LLC) Representative: ___________________________ Date: ___________________________

(Pharmacy & Clinic Copy – Please have Patient Sign & Return)
RECEIPT OF ADMISSION DOCUMENTATION

My signature on this form acknowledges I have received the following Rein Health’s admission documents. I understand these documents provide an explanation of services, my rights and responsibilities, the ways in which my health information may be used or disclosed by Rein Health and of my rights with respect to my health information. I also acknowledge receiving full instruction and have demonstrated my understanding in the proper use, operation and care of the equipment and/or supplies. I have been offered educational counseling regarding my medications and the opportunity to ask questions or concerns I may have regarding my medications. I understand the CMS Medicare DMEPOS Supplier Standards.

Admission Documentation
- Welcome Letter, Contact Information & After Hours On Call
- Notice of Privacy Practices
- Medicare Prescription Drug Coverage and Your Rights
- Rights of the Elderly
- CMS Guidelines
- Patient/Drug Specific Monograph

PATIENT NAME (PRINT): ___________________________ DOB: ____________

SIGN HERE

Patient’s Signature or Patient’s Representative ___________________________ Date ____________

Rein Health Representative ___________________________ Date ____________

TO BE COMPLETED BY REIN HEALTH REPRESENTATIVE IF FORM IS NOT SIGNED

1. Was the patient provided with a copy of Rein Health’s Admission documentation?
   □ Yes □ No

2. Briefly describe efforts made to obtain the patient’s acknowledgment of receipt of the admission documentation and explain why the patient or patient representative was not able or willing to sign this form:

   ____________________________________________________________

   ____________________________________________________________

Signature of Rein Health Representative ___________________________ Date ____________________
ADVANCE BENEFICIARY
NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare doesn’t pay for D. _____________ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D. _____________ below.

<table>
<thead>
<tr>
<th>D.</th>
<th>E. Reason Medicare May Not Pay</th>
<th>F. Estimated Cost</th>
</tr>
</thead>
</table>

WHAT YOU NEED TO DO NOW:
- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D. _____________ listed above.
  
  **Note:** If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS  
Check only one box. We cannot choose a box for you.
- **OPTION 1.** I want the D. _____________ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn’t pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
- **OPTION 2.** I want the D. _____________ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**
- **OPTION 3.** I don’t want the D. _____________ listed above. I understand with this choice I am not responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:  
J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.
Notice of Privacy Practices for Protected Health Information

This notice describes how medical information about you may be used and disclosed and how you can gain access to this information. Please review this carefully!

Americare Medical Partners, PLLC is a registered corporation in the state of Texas, hereinafter referred to as Rein Health.

Rein Health is permitted by federal law to make and use disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing services to you. Such information may include documenting your symptoms, examinations, test results, treatments, diagnoses, and future care or treatment. It also includes billing documents for these services.

Examples of uses of Your Health Information for Treatment Purposes are: The medical assistant records your vitals in your health record. The physician consults with a specialist to obtain his/her input.

Examples of uses of Your Health Information for Payment Purposes: Your health insurance company requests information regarding dates of services or treatment received.

Examples of uses of Your Health Information for Health Care Operations: We obtain services from other business associates for quality assurance, organizational development, process improvement, training, or legal services. We will share your information with such associates as necessary when these services are necessary.

Your Health Information Rights
The health and billing records we maintain are the physical property of clinic. The information in it, however, belongs to you. You have a right to:

- Request in writing to our clinic a restriction of your health information. We are not required to grant this request, but we will comply with any request granted.
- Obtain a paper copy of the current Notice of Privacy Practices for Protected Health Information (“Notice”) by making a request to our office.
- Request or inspect your health record at any time by making a request to our office.
- Appeal a denial of access to your protected health information, except in certain circumstances;
- Request that your health record be amended to correct incomplete or incorrect information by making a request to our clinic. We may deny the request if you ask us to correct or amend information that was not created by us, is not a part of the health record at our office, is not a part of the information you would be permitted to inspect or copy, or is already accurate and complete. (If your request is denied you will be informed of the reason for the denial and will have an opportunity to submit a statement of disagreement to be maintained in your health record.)
- Request that communication of your health information be made by alternative means or at an alternative location by submitting a written request to our office.
- Obtain an accounting of disclosures of your health information as required to be maintained by law by submitting a request to our office. An accounting will not include uses and disclosures of information for treatment, payment, or operations; disclosures or uses made to you or made at your request; uses or disclosures made pursuant to an authorization signed by you; uses or disclosures made in a facility directory or to a family member or friend relevant to that person’s involvement in your care or in payment for such care; or, uses or disclosures to notify family or others responsible for your care of your location, condition or your death.
- Revoke authorizations that you made previously to use or disclose information by delivering a written revocation to our office, except to the extent information or action has already been taken.

Our Responsibilities
Rein Health is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and,
- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our “Notice” or by visiting our office and picking up a copy. Please be advised that this office maintains our patients’ protected health information (“PHI”) in electronic form (“Electronic Health Records”). All Electronic Health Records maintained by this office, including your PHI, is subject to electronic disclosure.

Rein Health
2790 Lake Vista Dr. Lewisville, TX 75067 • Phone: 972-661-CARE • Fax: 1-866-292-6489

REV. 05-10-18
To Request Information or File a Complaint
If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact:
Practice Administrator 2790 Lake Vista Drive, Lewisville, TX 75067
Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to the practice administrator. You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services, whose street address and e-mail address can be obtained from the practice administrator. We cannot and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from our clinic. We cannot and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

Other Disclosures and Uses
Communication with Family: Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person your identify, health information, relevant to that person’s involvement in your care or in payment for such care if you do not object or in an emergency.
Notification: Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about location, condition, or in the case of emergency or death.
Research: We may disclose information to researchers when an institutional review board has reviewed the research, and established protocols to ensure the privacy of your protected health information has approved the research project.

Disaster Relief: We may use and disclose your protected health information to assist in disaster relief efforts.
Organ Procurement Organizations: Consistent with applicable law, we may disclose your protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Food and Drug Administration (FDA): We may disclose to the FDA your protected health information relating to adverse events with respect to food, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers Compensation: If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Public Health: As authorized by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability; to report reactions to medications or problems with products; to notify people of recalls; to notify a person who may have been exposed to a disease or who is at risk for contracting or spreading a disease or condition.

Abuse & Neglect: We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

Employers: We may release health information about you to your employer if we provide health care services to you at the request of your employer, and the health care services are provided either to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury. In such circumstances, we will give you written notice of such release of information to your employer. Any other disclosures to your employer will be made only if you execute a specific authorization for the release of that information to your employer.

Correctional Institutions: If you are an inmate of a correctional institution, we may disclose to the institution or its agents the protected health information necessary for your health and the health and safety of other individuals.

Law Enforcement: We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecution, or to the extent an individual is in the custody of law enforcement.

Health Oversight: Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

Judicial / Administrative Proceedings: We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your authorization, or as directed by a proper court order.

Serious Threat: To avert a serious threat to health or safety, we may disclose your protected health information consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public.

Specialized Governmental Functions: We may disclose your protected health information for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel.

Coroners, Medical Examiners, and Funeral Directors: We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients to funeral directors as necessary for them to carry out their duties.

Other Uses: Other uses and disclosures, besides those identified in this Notice, will be made only as otherwise required by law or with your written authorization and you may revoke the authorization as previously provided in this Notice under “Your Health Information Rights.”

Complaints about physicians, as well as other licensees and registrants of the Texas Medical Board, including physician assistants, acupuncturists, and surgical assistants may be reported for investigation at the following address:
Texas Medical Board Attention: Investigations
333 Guadalupe, Tower 3, Suite 610 or P.O. Box 2018, MC-263
Austin, TX 78787-2018

Assistance in filing a complaint is available by calling 1-800-210-9353 or visiting www.tmb.state.tx.us.
**Patient Copy**

**CMS MEDICARE DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUPPLIES (DMEPOS) SUPPLIER STANDARDS**

Note: This is an abbreviated version of the supplier standards every Medicare DMEPOS supplier must meet in order to obtain and retain their billing privileges. These standards, in their entirety, are listed in 42 C.F.R. 424.57(c).

1. A supplier must be in compliance with all applicable Federal and State licensure and regulatory requirements and cannot contract with an individual or entity to provide licensed services.
2. A supplier must provide complete and accurate information on the DMEPOS supplier application. Any changes to this information must be reported to the National Supplier Clearinghouse within 30 days.
3. An authorized individual (one whose signature is binding) must sign the application for billing privileges.
4. A supplier must fill orders from its own inventory, or must contract with other companies for the purchase of items necessary to fill the order. A supplier may not contract with any entity that is currently excluded from the Medicare program, any State health care programs, or from any other Federal procurement or non-procurement programs.
5. A supplier must advise beneficiaries that they may rent or purchase inexpensive or routinely purchased durable medical equipment, and of the purchase option for capped rental equipment.
6. A supplier must notify beneficiaries of warranty coverage and honor all warranties under applicable State law, and repair or replace free of charge Medicare covered items that are under warranty.
7. A supplier must maintain a physical facility on an appropriate site. This standard requires that the location is accessible to the public and staffed during posted hours of business. The location must be at least 200 square feet and contain space for storing records.
8. A supplier must permit CMS, or its agents to conduct on-site inspections to ascertain the supplier's compliance with these standards. The supplier location must be accessible to beneficiaries during reasonable business hours, and must maintain a visible sign and posted hours of operation.
9. A supplier must maintain a primary business telephone listed under the name of the business in a local directory or a toll free number available through directory assistance. The exclusive use of a beeper, answering machine, answering service or cell phone during posted business hours is prohibited.
10. A supplier must have comprehensive liability insurance in the amount of at least $500,000 that covers both the supplier's place of business and all customers and employees of the supplier. If the supplier's place of business is designed to also cover product liability and completed operations, the insurance must also cover product liability and completed operations.
11. A supplier must agree not to initiate telephone contact with beneficiaries, with a few exceptions allowed. This standard prohibits suppliers from contacting a Medicare beneficiary based on a physician’s oral order unless an exception applies.
12. A supplier is responsible for delivery and must instruct beneficiaries on use of Medicare covered items, and maintain proof of delivery.
13. A supplier must answer questions and respond to complaints of beneficiaries, and maintain documentation of such contacts.
14. A supplier must maintain and replace all no charge or repair directly, or through a service contract with another company. Medicare-covered items it has rented to beneficiaries.
15. A supplier must agree not to service or repair subcontracted Medicare covered items.
16. A supplier must provide complete and accurate information on the DMEPOS supplier application. Any changes to this information must be reported to the National Supplier Clearinghouse within 30 days.
17. A supplier must notify beneficiaries of warranty coverage and honor all warranties under applicable State law, and repair or replace free of charge Medicare covered items that are under warranty.
18. A supplier must maintain a primary business telephone listed under the name of the business in a local directory or a toll free number available through directory assistance. The exclusive use of a beeper, answering machine, answering service or cell phone during posted business hours is prohibited.
19. A supplier must have comprehensive liability insurance in the amount of at least $500,000 that covers both the supplier’s place of business and all customers and employees of the supplier. If the supplier’s place of business is designed to also cover product liability and completed operations, the insurance must also cover product liability and completed operations.
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22. A supplier must answer questions and respond to complaints of beneficiaries, and maintain documentation of such contacts.
23. A supplier must maintain and replace all no charge or repair directly, or through a service contract with another company. Medicare-covered items it has rented to beneficiaries.
24. A supplier must agree not to service or repair subcontracted Medicare covered items.
25. A supplier must agree not to initiate telephone contact with beneficiaries, with a few exceptions allowed. This standard prohibits suppliers from contacting a Medicare beneficiary based on a physician’s oral order unless an exception applies.
26. A supplier is responsible for delivery and must instruct beneficiaries on use of Medicare covered items, and maintain proof of delivery.
27. A supplier must answer questions and respond to complaints of beneficiaries, and maintain documentation of such contacts.
28. A supplier must maintain and replace all no charge or repair directly, or through a service contract with another company. Medicare-covered items it has rented to beneficiaries.
29. A supplier must agree not to service or repair subcontracted Medicare covered items.
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31. A supplier is responsible for delivery and must instruct beneficiaries on use of Medicare covered items, and maintain proof of delivery.
32. A supplier must answer questions and respond to complaints of beneficiaries, and maintain documentation of such contacts.
33. A supplier must maintain and replace all no charge or repair directly, or through a service contract with another company. Medicare-covered items it has rented to beneficiaries.
34. A supplier must agree not to service or repair subcontracted Medicare covered items.
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50. A supplier must agree not to initiate telephone contact with beneficiaries, with a few exceptions allowed. This standard prohibits suppliers from contacting a Medicare beneficiary based on a physician’s oral order unless an exception applies. 

**INSURANCE AND BILLING INFORMATION**

The Rein Health (AmeriCare Infusion Centers, LLC) billing department is designed to bill your insurance company for the services you receive from us. If you have coverage from more than one health insurance company, please inform us as to which company is primary and should be billed first. Since each health insurance policy coverage varies, we suggest you call your insurance company if you have any questions regarding your policy. Regardless of insurance coverage, you are ultimately responsible for your bill. If your insurance carrier has questions or requests additional information from you, please respond promptly. If you have any questions regarding the status of your claim, we suggest you contact your insurance company directly. The billing department is ready to answer billing and insurance questions and can be reached at 972-661-CARE (2273).

**FOR YOUR INFORMATION**

**EMERGENCY MANAGEMENT PLAN**

**Consumer Information**

Rein Health (AmeriCare Infusion Centers, LLC) shall provide to all patients at time of delivery of all life-sustaining or life-supporting medical equipment a copy of the Certified Emergency Management Plan.

**Personnel Responsibilities**

All patients and caregivers receiving life-sustaining or life-supporting equipment will be instructed and educated about maintaining equipment and supplies and will be supplied with an instruction manual and support numbers to call.

At time of delivery of all life-sustaining or life-supporting equipment a copy of the special needs registry will be presented to the patient and/or caregiver. At time of delivery of all life-sustaining or life-supporting equipment the patient and/or caregiver will be educated on the special needs registry. Including local shelters, things they will need to take, evacuation, etc.

Patients and/or caregivers receiving life-sustaining or life-supporting equipment that are not currently registered with the special needs registry will be given an application and advised of Rein Health (AmeriCare Infusion Centers, LLC) CEMP prior to, during and immediately following an emergency.

**Equipment and Supply List**

At time of delivery the patient and/or caregiver will be provided with an updated equipment and supply list describing all life-sustaining or life-supporting equipment and supplies that will they will need to take with them if they are evacuated to a special needs shelter in their area.

**NOTIFICATION OF A POSSIBLE EMERGENCY**

All Rein Health (AmeriCare Infusion Centers, LLC) personnel will be alerted by the General Manager or the Assistant General Manager of any and all impending emergency situations and the implementation of the CEMP will be activated. All Rein Health (AmeriCare Infusion Centers, LLC) contractors will be notified of the implementation of the CEMP pending any and all emergency situations. All Rein Health (AmeriCare Infusion Centers, LLC) personnel will follow the instructions given by the General Manager or the Assistant General Manager regarding reporting to work in the event of an emergency and the office/facility remains operational.

All patients and/or caregivers receiving any life-sustaining or life-supporting equipment will be notified of the precautionary measures that will be taken, but not limited to, the continuation of the same type of care and quantity of care, evacuation to special needs shelters, unless an emergency situation is beyond our control to special needs and/or caregivers using any life-sustaining or life-supporting equipment will be provided with a list of alternate telephone numbers in the event that the primary notification system should fail. A prioritized list of patients receiving life-sustaining or life-supporting equipment shall be maintained and made available to the county health department and local emergency management agency when requested. This list shall indicate the means by which services shall be continued for each patient, whether the patient has life-sustaining or life-supporting equipment, including the specific type of equipment and related supplies.
Evacuation

All patients will receive updated equipment and supplies list to be kept in their residence when life-sustaining or life-supporting equipment is delivered. At time of delivery of all life-sustaining or life-supporting equipment the patient and/or caregiver will be educated on the special needs registry. Including local shelters, things they will need to take, evacuation, etc. During a mandatory evacuation all Rein Health (AmeriCare Infusion Centers, LLC) personnel will not only educate but shall lend assistance to the patient or caregiver to ensure adequate equipment and supplies are provided.

Rein Health (AmeriCare Infusion Centers, LLC) shall deliver essential equipment, services and/or referrals to other organizations subject to written agreements including how Rein Health (AmeriCare Infusion Centers, LLC) will continue to provide service to consumers who relocate within or outside the geographic service area.

SCOPE OF SERVICES

AmeriCare Infusion Centers, Inc. will provide patients, caregivers, customers, facilities and referrals with general information concerning our staff and time frame for completing physician orders and delivery times.

- Rein Health (AmeriCare Infusion Centers, LLC) staff will notify patients, caregivers, customers, facilities and referrals when a Service Technician or delivery personnel is expected to deliver or service equipment with an approximate or estimated delivery time.
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STATE ABUSE HOTLINE NUMBER: 1-800-252-5400

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Se la presentado a usted, informacion acerca el escrito de esta receta. Porfavor de leer esta informacion antes de tomar el medicamento. Si usted tiene preguntas sobre esta receta, nuestro Farmaceutico estara disponible para contester sus preguntas durante las horas normal de negocia, Lunes a Viernes de 9:00 am – 5:00 pm.

CLINIC NOTICE: If you have any questions concerning your health care services, a nurse/doctor is available during normal business hours to answer these questions Monday – Friday 9:00 am – 5:00 pm.

Phone: 972-661-2273 Fax: 1-866-292-6489

Complaints about physicians, as well as other licensees and registrants of the Texas Medical Board, including physician assistants, acupuncturists, and surgical assistants may be reported for investigation at the following address:

Texas Medical Board Attention: Investigations
333 Guadalupe, Tower 3, Suite 610 or P.O. Box 2018, MC-263
Austin, TX 78787-2018

Assistance in filing a complaint is available by calling 1-800-210-9353 or visiting www.tmb.state.tx.us

Las quejas sobre medicos, asi como sobre otros profesionales acreditados e inscritos en la Junta de Examinadores Medicos del Estado de Texas, incluyendo asistentes de medicos, practicantes de acupuntura y asistentes de cirugia, se pueden presentar en la siguiente direccion para ser investigadas:

Texas Medical Board Attention: Investigations
333 Guadalupe, Tower 3, Suite 610 or P.O. Box 2018, MC-263
Austin, TX 78787-2018

Si necesita ayuda para presentar una queja, llame al: 1-800-210-9353

Para obtener mas informacion, visite nuestro sitio web en www.tmb.state.tx.us
MEDICARE PRESCRIPTION DRUG COVERAGE AND YOUR RIGHTS

You have the right to request a coverage determination and get a written explanation from your Medicare drug plan if:

- Your prescriber or pharmacist tells you that your Medicare drug plan will not cover a prescription drug in the amount or form prescribed; or
- You are asked to pay a different cost-sharing amount than you think you are required to pay for a prescription drug.

You also have the right to ask your Medicare drug plan for an exception (a special type of coverage determination) and get a written explanation from your Medicare drug plan if:

- You believe you need a drug that is not on your drug plan’s list of covered drugs. The list of covered drugs is called a “formulary;”
- You believe a coverage rule (such as prior authorization or a quantity limit) should not apply to you for medical reasons; or
- You believe you should get a drug you need at a lower cost-sharing amount.

What you need to do:

- Contact your Medicare drug plan to ask for a coverage determination, including an exception request.
- Refer to the benefits booklet you received from your Medicare drug plan or call 1-800-MEDICARE to find out how to contact your drug plan.
- When you contact your Medicare drug plan, be ready to tell them:
  1. The prescription drug(s) that you believe you need. Include the dose and strength, if known.
  2. The name of the pharmacy or prescriber who told you that the prescription drug(s) is not covered.
  3. The date you were told that the prescription drug(s) is not covered.

The Medicare drug plan’s written explanation will give you the specific reasons why the prescription drug is not covered and will explain how to request an appeal if you disagree with the drug plan’s decision.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0975. The time required to complete this information collection is estimated to average one minute per response, including the time to select the preprinted form, and hand it to the enrollee. If you have any comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Sec. 102.001. DEFINITIONS.  RIGHTS OF THE ELDERLY

(1) "Convalescent and nursing home" means an institution licensed by the Texas Department of Human Services under Chapter 242, Health and Safety Code.

(2) "Home health services" means the provision of health service for pay or other consideration in a patient’s residence regulated under Chapter 142, Health and Safety Code.

(3) "Alternate care" means services within an elderly individual’s own home, neighborhood, or community including:
   (A) day care;
   (B) foster care;
   (C) alternative living plans, including personal care services; and
   (D) supportive living services, including attendant care, residential repair, or emergency response services.

(4) "Person providing services" means an individual, corporation, association, partnership, or other private or public entity providing convalescent and nursing home services, home health services, or alternate care services.

(5) "Elderly individual" means an individual 50 years of age or older.

Sec. 102.002. PROHIBITION.

(a) A person providing services to the elderly may not deny an elderly individual a right guaranteed by this chapter.

(b) Each agency that licenses, registers, or certifies a person providing services shall require the person to implement and enforce this chapter. A violation of this chapter is grounds for suspension or revocation of the license, registration, or certification of a person providing services.

Sec. 102.003. RIGHTS OF THE ELDERLY.

(a) An elderly individual has all the rights, benefits, responsibilities, and privileges granted by the constitution and laws of this state and the United States, except where lawfully restricted. The elderly individual has the right to be free of interference, coercion, discrimination, and reprisal in exercising these civil rights.

(b) An elderly individual has the right to be treated with dignity and respect for the personal integrity of the individual without regard to race, religion, national origin, sex, age, disability, marital status, or source of payment. This means that the elderly individual:
   (1) has the right to make the individual’s own choices regarding the individual’s personal affairs, care, benefits, and services;
   (2) has the right to be free from abuse, neglect, and exploitation; and
   (3) if protective measures are required, has the right to designate a guardian or representative to ensure the right to quality stewardship of the individual’s affairs.

(c) An elderly individual has the right to be free from physical and mental abuse, including corporal punishment or physical or chemical restraints that are administered for the purpose of discipline or convenience and not required to treat the individual’s medical symptoms. A person providing services may use physical or chemical restraints only if the use is authorized in writing by a physician or the use is necessary in an emergency to protect the elderly individual or others from injury. A physician’s written authorization for the use of restraints must specify the circumstances under which the restraints may be used and the duration for which the restraints may be used. Except in an emergency, restraints may only be administered by qualified medical personnel.

(d) A mentally retarded elderly individual with a court-appointed guardian of the person may participate in a behavior modification program involving use of restraints or adverse stimuli only with the informed consent of the guardian.

(e) An elderly individual may not be prohibited from communicating in the individual’s native language with other individuals or employees for the purpose of acquiring or providing any type of treatment, care, or services.

(f) An elderly individual may complain about the individual’s care or treatment. The complaint may be made anonymously or communicated by a person designated by the elderly individual. The person providing the service shall promptly respond to resolve the complaint. The person providing services may not discriminate or take other punitive action against an elderly individual who makes a complaint.

(g) An elderly individual is entitled to privacy while attending to personal needs and a private place for receiving visitors or associating with other individuals unless providing privacy would infringe on the rights of other individuals. This right applies to medical treatment. Written communications, telephone conversations, meeting with family, and access to resident councils. An elderly person may send and receive unopened mail, and the person providing services shall ensure that the individual’s mail is sent and delivered promptly. If an elderly individual is married and the spouse is receiving similar services, the couple may share a room.

(h) An elderly individual may participate in activities of social, religious or community groups unless the participation interferes with the rights of other persons.

(i) An elderly individual may manage the individual’s personal financial affairs. The elderly individual may authorize in writing another person to manage the individual’s money. The elderly individual may choose the manner in which the individual’s money is managed, including a money management program, a representative payee program, a financial power of attorney, a trust or a similar method, and the individual may choose the least restrictive of these methods. A person designated to manage an elderly individual’s money shall do so in accordance with each applicable program policy, law, or rule. On request of the elderly individual or the individual’s representative, the person designated to manage the elderly individual’s money shall make available the related financial records and provide an accounting of the money. An elderly individual’s designation of another person to manage the individual’s money does not affect the individual’s ability to exercise another right described by this chapter. If an elderly individual is unable to designate another person to manage the individual’s affairs and a guardian is designated by a court, the guardian shall manage the individual’s money in accordance with the Probate Code and other applicable laws.

(j) An elderly individual is entitled to access to the individual’s personal and clinical records. These records are confidential and may not be released without the elderly individual’s consent, except the records may be released:
   (1) to another person providing services at the time the elderly individual is transferred; or
   (2) if the release is required by another law.

(k) A person providing services shall fully inform an elderly individual, in language that the individual can understand, of the individual’s total medical condition and shall notify the individual whenever there is a significant change in the person’s medical condition.

(l) An elderly individual may choose and retain a personal physician and is entitled to be fully informed in advance about treatment or care that may affect the individual’s well-being.

(m) An elderly individual may participate in an individual plan of care that describes the individual’s medical, nursing and psychosocial needs and how the needs will be met.
An elderly individual may refuse medical treatment after the elderly individual:

1. is advised by the person providing the services of the possible consequences of refusing treatment; and
2. acknowledges that the individual clearly understands the consequences of refusing treatment.

An elderly individual may retain and use personal possessions, including clothing and furnishings, as space permits. The number of personal possessions may be limited for the health and safety of other individuals.

An elderly individual may refuse to perform services for the person providing services.

Not later than the 30th day after the date the elderly individual is admitted for service, a person providing services shall inform the individual:

1. whether the individual is entitled to benefits under Medicare or Medicaid; and
2. which items and services are covered by these benefits, including items or services for which the elderly individual may not be charged.

A person providing services may not transfer or discharge an elderly individual unless:

1. the transfer is for the elderly individual’s welfare, and the individual’s needs cannot be met by the person providing services;
2. the elderly individual’s health is improved sufficiently so that services are no longer needed;
3. the elderly individual’s health and safety or the health and safety of another individual would be endangered if the transfer or discharge was not made;
4. the person providing services ceases to operate or to participate in the program that reimburses the person providing services for the elderly individual’s treatment or care; or
5. the elderly individual fails, after reasonable and appropriate notices, to pay for services.

Not in an emergency, a person providing services may not transfer or discharge an elderly individual from a residential facility until the 30th day after the date the person providing services provides written notice to the elderly individual, the individual’s legal representative, or a member of the individual’s family stating:

1. that the person providing services intends to transfer or discharge the individual;
2. the reason for the transfer or discharge listed in Subsection (r);
3. the effective date of the transfer or discharge;
4. if the individual is to be transferred, the location to which the individual will be transferred; and
5. the individual’s right to appeal the action and the person to whom the appeal should be directed.

An elderly individual may:

1. make a living will by executing a directive under he Natural Death Act (Chapter 672, Health and Safety Code);
2. execute a durable power of attorney for health care under Chapter 135, Civil Practice and Remedies Code or
3. designate a guardian in advance of need to make decisions regarding the individual’s health care should the individual become incapacitated.

Sec. 102.004. LIST OF RIGHTS.

(a) A person providing services shall provide each elderly individual with a written list of the individual’s rights and responsibilities, including each provision of Section 102.003, before providing services or as soon after providing services as possible, and shall Post the list in a conspicuous location.

(b) A person providing services must inform an elderly individual of changes or revisions in the list.

Sec. 102.005. RIGHTS CUMULATIVE. The rights described in this chapter are cumulative of other rights or remedies to which an elderly individual may be entitled under law.