CASTILLO MEDICAL SERVICES, INC.

6355 NW 36th ST. SUITE 502-A
VIRGINIA GARDENS, FL 33166
TELEPHONE (305) 871-8076 & FAX (305) 871-8077

INVOICE [ ] [ ] PICK UP [ ] DELIVERY

DATE _____ TIME _____
SHIP TO (OR RECEIVED FROM) _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____
PHONE _____ D.O.B. _____ DOCTOR _____
MEDICARE NO. _____ MEDICAID NO. _____ INS CO. _____
ORDER RECEIVED (DATE) _____ RENTAL PERIOD FROM _____ TO _____

QUANTITY	RENTED (X)	DESCRIPTION	AMOUNT
		[ ] COMPRESSOR / NEBULIZER NO. _____ [ ] NEBULIZER KITS _____	
		[ ] AIR MATTRESS [ ] 5" [ ] 8"	
		CUSHION [ ] SEAT [ ] BACK	
		[ ] H OXYGEN SET UP [ ] E OXYGEN SET UP [ ] BASE	
		[ ] PORTABLE O2 [ ] REGULATOR [ ] CART	
		[ ] HUMIDIFER _____ [ ] NASAL CANNULAS [ ] 7" [ ] 25" [ ] MASK _____	
		[ ] CONCENTRATOR TYPE _____ SERIAL # _____	
		[ ] SUCTION PUMP TYPE _____ NO. _____	
		[ ] WHEELCHAIR TYPE [ ] STD [ ] E/L [ ] L/W [ ] POWER WC	
		[ ] HOSPITAL BED TYPE [ ] ELEC. [ ] STD NO. _____	
		[ ] SIDE RAILS [ ] TRAPEZE [ ] SHOWER CHAIR	
		[ ] BED MATRESS [ ] PATIENT LIFT [ ] COMMODE	
		[ ] GLUCOMETER [ ] GLUCO STICKS _____ [ ] LANCETS _____	
		[ ] LEG BAGS [ ] DRAINAGE BAGS [ ] FOLEY CATHETER	
		[ ] TENS UNITS	
		[ ] ENTERAL NUTRITION SOLUTIONS	
		[ ] CPAP [ ] BIPAP [ ] MASK	
		[ ] ENTERAL NUTRITION SOLUTIONS	
		[ ] POWER OPERATED VEHICLES (SCOOTERS)	

TOTAL $ _____

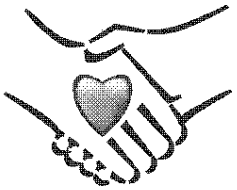
RECEIVED ON ACCT $ _____ CHECK _____ CASH _____

EMPTY CYLS RETURNED H _____

DELIVERED OR RECEIVED BY: _____ CUSTOMER SIGNATURE: _____

ANY PORTION OF CLAIM NOT PAID BY MEDICARE WILL BE CHARGED BACK TO YOUR ACCOUNT.

F15



HOME CARE SERVICES PROVIDER

7000 SW 97 Ave. Suite 201, Miami, FL 33173
Ph: (305) 262-2287
Fax: (305) 262-2297

INVOICE #

Ship to: _____	Date: Time:
Or Received From	Phone:
Address: _____ Apt: _____	D.O.B.:
	Medicare #:
	BS/FI No.:
	Medicaid #:
	Other:
City: _____ State: _____ Zip: _____	Doctor:
	Phone:
	UPIN:

☐ INVOICE SALE ☐ INVOICE RENTAL

QUANTITY		Rented	DESCRIPTION
ORDERED	SHIPPED	(X)	

ANY PORTION OF CLAIM NOT PAID BY MEDICARE WILL BE CHARGED BACK TO YOUR ACCOUNT.	DELIVERED OR RECEIVED BY: _____	CUSTOMER SIGNATURE: X _____

Las Mercedes Home Care, Corp.

2103 Coral Way Suite # 401-404
Miami, FL 33145
Ph: (305) 857-9808 Fax: (305) 857-9906

INVOICE

DATE _____ TIME _____
PHONE _____
MEDICARE NO. _____
BS/FL NO. _____
MEDICAID NO. _____
OTHER _____
DOCTOR _____
PHONE _____
RX _____
_____

SHIP TO (OR
RECD. FROM) _____

ADDRESS _____ APT NO. _____

CITY _____ STATE _____ ZIP _____

□ INVOICE □ INVOICE-RENTAL REBILLING □ RECEIVING RECORD □ PAYMENT RECEIPT □ CREDIT MEMO

Order Rec'd (Date)		Customer Order No.	Rental Period From _____ to _____	Terms □ Pay on Receipt of Inv. □ Net 15th Prox. □ Cash Sale

Quantity Ordered	Quantity Shipped	Rented (x)	DESCRIPTION	UNIT PRICE	AMOUNT	
			□ COMPRESSOR □ SAN □ NEBULIZER □ IMMERSION HEATER			
			□ USN No. MODEL			
			□ VENTILATOR MODEL No.			
			□ OXYGEN SET UP □ E OXYGEN SET UP □ CART □ BASE			
			□ D OXYGEN SET UP □ MADA PORTABLE TYPE			
			□ LOX SET UP □ GR □ ST □ TR □ WA			
			□ LOX SET UP PB 31 No. PB 1000 No.			
			□ 244 Ct. FT. (H) □ 23 CU FT (E) □ 14 CU FT. (D)			
			□ LIQUID OXYGEN REFILL (LBS.)			
			□ CONCENTRATOR TYPE No.			
			□ SUCTION □ IPPB TYPE No.			
			□ WHEELCHAIR TYPE □ STD □ E/L □ L/W			
			□ HOSPITAL BED TYPE □ ELEC. □ STD. □ HI-LO			
			□ SIDE RAILS □ TRAPEZE □ ROLL ABOUT CHAIR			
			□ OVERBED TABLE □ PATIENT LIFTER □ COMMODE			
			□ T.E.N.S. UNIT			
			□ BLOOD GLUCOMETER □ SUPPLIES			

AMT RECEIVED

ON THIS INVOICE $ _____

ON ACCT. $ _____

CHECK _____

CASH _____

ANY PORTION OF CLAIM NOT PAID BY MEDICARE WILL BE CHARGED BACK TO YOUR ACCOUNT

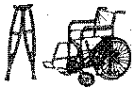
TOTAL $

EMPTY CYLS RETURNED	H			MADA	B	D	E	F	M	G	H (NOT

DELIVERED OR RECEIVED BY

CUSTOMER SIGNATURE

CUSTOMER SIGNATURE SIGNIFIES ACCEPTANCE OF CONDITIONS STATED



M.F. Medical Supplies, Inc.

7035-H SW 47 St.
Miami, Florida 33155
Office: (305) 662-4435
Beeper: (305) 657-3639
Fax: (305) 722-0266
Cell: (786) 395-1450
Cell: (305) 297-9039

INVOICE

DATE	TIME
PHONE	
MEDICARE No.	
BS/FL No.	
MEDICAID No.	
OTHER	
DOCTOR	
PHONE	
RX	

SHIP TO (OR REC'D FROM) _____

ADDRESS _____ APT No. _____

CITY _____ STATE _____ ZIP _____

☐ INVOICE ☐ INVOICE-RENTAL RE BILLING ☐ RECEIVING RECORD REC'D. BY SRC ☐ PAYMENT RECEIPT ☐ CREDIT MEMO

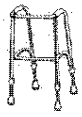
Order Rec'd (Date)	Customer Order No.	Rental Period From _____ To _____	Terms: ☐ Pay On Receipt Of Invoice ☐ Net 15th Prox ☐ Cash Sale

Quantity Ordered	Quantity Shipped	Rented (X)	Description	Unit Price	AMOUNT
			☐ COMPRESSOR ☐ SAN ☐ NEBULIZER ☐ IMMERSION HEATER		
			☐ ,H OXYGEN SET UP ☐ E OXYGEN SET UP ☐ CART ☐ BASE		
			☐ D OXYGEN SET UP		
			☐ 244 CU. FT (H) ☐ 23 CU.FT (E) ☐ 14 CU. FT (D)		
			☐ CONCENTRATOR TYPE No.		
			☐ SUCTION ☐ IPPS TYPE No.		
			☐ WHEELCHAIR TYPE ☐ STD. ☐ E/L ☐ L/W		
			☐ HOSPITAL BED TYPE ☐ ELEC ☐ STD. ☐ HI-1-0		
			☐ SIDE RAILS ☐ TRAPEZE ☐ ROLL ABOUT CHAIR		
			☐ OVERBED TABLE ☐ PATIENT LIFTER ☐ COMMODE		
			☐ GLUCOMETER		
			☐ CANES ☐ STANDARD ☐ 3 LEGGED ☐ QUAD		
			☐ F. WALKER		
			☐ OTHERS		

ANY PORTION OF CLAIM NOT PAID BY MEDICARE WILL BE CHARGED BACK TO YOUR ACCOUNT		TOTAL$	
	DELIVERED RECEIVED BY:	CUSTOMER SIGNATURE x	

MGW Medical Services, Inc.

11300 N.W. 87th Court, Suite 158
Hialeah Gardens, Fl 33016
Phone: (305) 827-2160 Fax: (305) 827-2168



INVOICE

DATE	TIME
PHONE	
MEDICARE No.	
BS/Fl No.	
MEDICAID No.	
OTHER	
DOCTOR	
PHONE	
Rx	
B/D	

SHIP TO (OR REC'D. FROM) _____

ADDRESS _____

APT. No. _____

CITY _____ *STATE* _____ *ZIP* _____

☐ *INVOICE* ☐ Invoice -Rental *REBILLING* ☐ *RECEIVING RECORD* ☐ PAYMENT' RECEIPT ☐ *CREDIT MEMO*

RECEIVED BY
MGW MEDICAL SERVICES, INC.

Order Rec'd (Date)	Customer Order No.	*Rental Period* *From* _____ *To* _____	*TERMS:* ☐ Pay on receipt of Invoice ☐ NET 15th Prox. ☐ Cash Sale

Quantity *Ord.*	Quantity *Ship*	*Rented* (X)	DESCRIPTION	*Unit Price*	*AMOUNT*
			☐ Compressor ☐ SAN ☐ Compressor ☐ Compressor ☐ *H OXYGEN SET UP* ☐ *E OXYGEN SET UP* ☐ *CART* ☐ *BASE* ☐ *DOXYGEN SET UP* ☐ *244 Cu. Ft. (H)* ☐ *23 Cu. Ft (E)* ☐ *14 Cu. Ft (D)* ☐ CONCENTRATOR Type: _____ No: _____ ☐ *SUCTION* ☐ *IPPB* Type: _____ No.: _____ ☐ WHEELCHAIR *Type:* ☐ *Standard* ☐ *E/L* ☐ *L/W* ☐ *HOSPITAL BED* *Type:* ☐ *Electric* ☐ *Standard* ☐ *Hi-Lo* ☐ SIDE RAILS ☐ TRAPEZE ☐ ROLL-ABOUT CHAIR ☐ OVERBED TABLE ☐ PATIENT LIFTER ☐ *COMMODE* ☐ GLUCOMETER ☐ *CANES* *Type:* O *Standard* O *3-Legged* O *Cuad* ☐ *F. WALKER* ☐ *OTHERS*		
				TOTAL $	

ANY PORTION OF CLAIM NOT PAID BY MEDICARE WILL BE CHARGED BACK TO YOUR ACCOUNT.

DELIVERED OR RECEIVED BY.	*CUSTOMER SIGNATURE* x

MIRACLE BLESSED CARE, ENT. INC.
470 EAST 4th AVE.
HIALEAH, FL 33010
(305) 887-6255

INVOICE

Date:	
Time:	
Medicare:	
Medicaid:	
Doctor:	
Ph:	

SHIP TO: _____
REC'D FROM: _____
ADDRESS: _____
APT _____ CITY _____ STATE _____
ZIP _____
PH _____

Order Rec'd DATE:	Customer Order No.	Rental Period From _____ to _____	Terms ☐ Pay on receipt ☐ Net 15th prox. ☐ Cash sale

Quantity Ord.	Ship	Rented (x)	Description	Unit Price	AMOUNT
			☐ Concentrator Model: _____/serial: _____ Hours: _____		
			☐ Portable O2 tank No _____ Exp _____		
			☐ Nasal cannula ☐ Aerosol mask / ___ kid/ ___ adult ☐ Nebulizer kit		
			☐ Compressor ☐ San ☐ Nebulizer/Model _____ ☐ Immersion heater ☐ US NEB. / Model		
			☐ Suction ☐ IPPB/Type _____		
			☐ W/C Type ___ STD ___ L/W ___ E/L		
			☐ Hospital Bed Type ___ Elect. ___ STD ___ HI-LO		
			☐ Glucometer/Brand _____ ☐ Lancets/Amounts _____ ☐ Strips/Amount _____		
			☐ Canes: ___ STD ___ 3 Legged ___ Cuad. ___ F. Walker ☐ Bedsidecommode		
			☐ Patient Lifter ☐ Trapeze		

Delivered By or Received By:	Customer (Patient) Signature: x

Terms and Conditions

1-Rental Equipment covered by this invoice will be maintained and serviced by an DME company (patient) must give MBC company reasonable notice that such maintenance and/or service is required.
2-MBC may take special service charge for after-hour Saturday and Sunday calls for service, pickups, or deliveries requested by customers.
3-Equipment hereby rented is at the rental rates listed on this invoice. Such equipment will continue on a rental basis until returned or purchased by customer. MBC will make no refund or deduction of charges for any unused portion of any rental period.
4-Miracle Blessed Care will not be responsible for any injury or damage resulting from the use of this equipment.
5-Customer will be responsible for any loss or damage to rental equipment from fire, theft, carelessness, or any cause other than reasonable wear.
6-Customer will not move rental equipment without written permission of our medical company.
7-Equipment rented hereunder, remains the property of Miracle Blessed Care, Ent. Inc.
8-Customer will be responsible for any portion of claim not paid by Medicare/Medicaid or any other Insurance.

CAUTION

- ☐ *OIL OR GREASE OF ANY KIND MUST NOT BE USED ON CYLINDER VALVES, GAUGES, REGULATORS OR OTHER FITTINGS*
- ☐ *NO SMOKING IF OXYGEN IN USE*

TEODULO EQUIPMENT & ORTHOPEDIC SUPPLY, INC.

"Quality, Respect and Efficient For Our Customers"
4355 W 16 AVE. SUITE 203B
Hialeah, FL 33012

Date	Invoice #

Bill To

Accredited Facility

Board for Orthotist/Prosthetist Certification
THE ADVANTAGE IS EXPERIENCE.

Terms	Due Date	Rep	Ship Date	Ship Via

Item	Quantity	Description	Price Each	Amount

We appreciate your prompt payment.

Subtotal	
Sales Tax ( )	
Total	
Balance Due	

Phone: (305) 558-5700 Fax: (305) 558-5085
Toll Free Number:
866 (HME) 463-2800
866 (HME) 363-4500
E-Mail: teoshme@yahoo.com

YEMA HOME HEALTH CARE , INC.
7845 Coral Way.
MIAMI, FL 33155
Phone: 305-262-2287 Fax: 305-262-2297

INVOICE #	
Date:	TIME:
Phone:	
D.O.B:	
Medicare #	
BS/FI NO.	
Medicaid #	
Other	
Doctor:	
Phone:	
UPIN:	

Ship to: _____

Or Received From

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

☐ INVOICE SALE ☐ INVOICE RENTAL

QUANTITY		Rented	DESCRIPTION					
ORDERED	SHIPPED	(X)						

ANY PORTION OF CLAIM NOT PAID BY MEDICARE WILL BE CHARGED BACK TO YOUR ACCOUNT.

DELIVERED OR RECEIVED BY: _____

CUSTOMER SIGNATURE

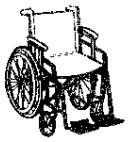
X _____

MEDICARE 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.
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.
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 or cell phone 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 calling beneficiaries in order to solicit new business.
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 supplier 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). *Implementation date- May 4, 2009*

SPANISH VERSION

1. El suplidor deberá cumplir con toda licencia aplicable del Gobierno Federal y Estatal y con todo requerimiento regulatorio.
2. El suplidor deberá proveer información completa y actualizada en la solicitud para suplidor de DMEPOS. Cualquier cambio de ésta información deberá ser reportado al National Supplier Clearinghouse en 30 dias.
3. Una persona autorizada (alguien cuya firma obligue a la compañía) deberá firmar la solicitud para obtener privilegios de facturación.
4. El suplidor dispensará las recetas/órdenes de su propio inventario o deberá tener un contrato con otras compañías para la compra de los artículos necesarios para dispensar las recetas/ordenes. El suplidor no podrá tener contratos con ninguna entidad que esté excluida del programa de Medicare, cualquier programa de salud Estatal, o de los programas Federales de procuramiento y no procuramiento.
5. El suplidor deberá informar a los beneficiarios de que pueden alquilar o comprar equipo médico durable económico o rutinariamente comprado, y de la opción de compra de los equipos alquilados una vez que lleguen a su término de alquiler.
6. El suplidor deberá notificar a los beneficiarios de la covertura de las garantías y honrar toda garantía aplicable bajo la ley Estatal, y reparar o remplazar sin costo alguno, todo artículo cubierto por Medicare.
7. El suplidor deberá mantener un local físico en un lugar apropiado.
8. El suplidor deberá permitirle a CMS (previamente conocido como HCFA) o a sus agentes, que conduzcan inspecciones para asegurar que el suplidor esté en cumplimiento con estos estándares. El local del suplidor deberá estar accesible a los beneficiarios durante horas de negocios razonables, y deberá mantener un rótulo y las horas de operación visibles.
9. El suplidor debe mantener una línea de teléfono para el negocio la cual esté registrada bajo el nombre del negocio en el directorio local, o un número sin costo, disponible através de la asistencia de la operadora. El uso exclusivo de un beeper, de una grabadora/contestadora o de un teléfono celular, está prohibido.
10. El suplidor debe tener seguro comprensivo de riesgo y responsabilidad de $ 300,000 que cubra el negocio, y, los clientes y empleados del suplidor. Si el suplidor manufactura sus propios artículos, este seguro debe también cubrir riesgo y responabilidad del producto y la operación en su totalidad.
11. El suplidor debe estar de acuerdo en no iniciar contacto telefónico con beneficiarios, con algunas excepciones. Este estándard les prohibe a los suplidores llamar a los beneficiarios con el fin de solicitar clientes nuevos.
12. El suplidor es responsable de entregar y explicar a los beneficiarios cómo usar todo artículo cubierto por Medicare, y mantener prueba de entrega.
13. El suplidor debe contestar preguntas y responder a toda queja que los beneficiarios tengan, y mantener documentación de dichos contactos.
14. El suplidor debe dar mantenimiento y remplazar sin costo alguno o reparar directamente, o através de un contrato de servicio con otra compañía, artículos cubiertos por Medicare que el suplidor haya alquilado a los beneficiarios.
15. El suplidor aceptará devoluciones de artículos de baja calidad, o inapropiados de los beneficiarios (artículos cuya calidad es inferior a la establecida para dicho artículo y/o artículos que son inapropiados para el beneficiario en el momento de haber sido medidos y alquilados o vendidos).
16. El suplidor debe revelar estos estándares para suplidores a cada beneficiario a quien provee artículos cubiertos por Medicare.
17. El suplidor debe revelar al Govierno toda persona dueña, que tenga participación financiera o participación en el control del negocio.
18. El suplidor no deberá transferir o reasignar el número de suplidor (ej.: el suplidor no puede vender o permitir que otra entidad use su número de suplidor de Medicare).
19. El suplidor debe establecer un plan para resolver quejas de los beneficiarios relacionadas a éstos estándares. Un registro de éstas quejas deberá ser mantenido en el local físico.
20. El registro de las quejas debe incluir: el nombre, dirección, número de teléfono y el número de Medicare (HICN) del beneficiario, y un resúmen de la queja y cualquier acción tomada para resolverla.
21. El suplidor debe acceder a proporcionarle a CMS (previamente conocido como HCFA) cualquier información requerida por el estatuto y regulaciones de implementación de Medicare.
22. Todo suplidor debe ser acreditado por una organización de acreditación aprobada por CMS para obtener y retener sus privilegios para facturación. La acreditación debe indicar los productos y servicios específicos para los cuales el suplidor es acreditado, para que el suplidor reciba pago para aquellos productos (excepto ciertos productos farmacéuticos exentos).
23. Todo suplidor debe notificar a su organización de acreditación cuando abre un nuevo local de DMEPOS.
24. Cada local del suplidor, poseído o subcontratado, debe cumplir con los estándares de calidad de DMEPOS y ser acreditado por separado para facturar a Medicare.
25. Todo suplidor debe revelar durante el periodo de inscripción, todos sus productos y servicios, incluso la adición de nuevos productos para los cuales esta solicitando acreditación.
26. Debe cumplir con los requisitos de fianza de garantía especificados en el párrafo (d) de ésta sección.



Lima Medical Equipment, Inc.

Ph: (305) 883-7172 * Fax: (305) 883-8911
2891 West 2nd Avenue - Hialeah, Florida 33010

PAYMENT AUTHORIZATION

Request that all payments for benefits approved by Medicare or another private insurance carrier, be paid to Lima Medical Equipment, Inc. for services rendered by the above provider.

I am authorizing the release of my personal information to Health Care Financing Administration agents. This includes any information necessary to determine eligibility of benefits for any determined service a copy of this original authorization to be deemed as an original authorization to be deemed as an original document.

I authorize the release of medical information to any accrediting body.

Additionally, I acknowledge receipt of the Supplier Standard List

REQUIRE OF THE SIGNATURE OF THE BENEFICIARY

Each invoice submitted for payment to Medicare must have the patient's signature in the Block under HCFA-1500. If the patient is incapacitated and unable to sign, the below listed instructions will be strictly adhered to, appropriate signature is obtained from the beneficiary's representative may be a legal guardian, a representative, a relative or a friend. If the patient is receiving care from an institution, an employee or one of the institution (preferable the administrator) must sign on behalf of the beneficiary; except in the case of an incapacitated beneficiary, the provider and or the representative are not permitted to sign for the patient. The patient's representative must:

1. **Sign the beneficiary's full name**
2. **Followed by the word "by"**
3. **Representative's Signature**
4. **State the relationship to the patient**
5. **State the reason why the incapacitated patient is unable to sign**

If the patient is not apt to reading or writing, but is able to sign with a "mark", he or she must have a witness complete the following:

1. **Have the patient sign with a "mark"**
2. **The witness must write "Witnessed By"**
3. **Witness Signature**
4. **Witness will state full address**

If the witness is an employee of the provider, the witness does not have to provide their address.

PATIENT UNDERSTANDS HIS/HER RIGHTS AND RESPONSIBILITIES AS STATED ON THE REVERSE SIDE OF THIS FORM.

_____ _____
Patient's Signature **Effective Date**

_____ **By** _____ _____
Patient's Name **Representative's Signature** **Relationship**

_____
If applicable, state the reason why patient is unable to sign.

THANK YOU

LIMA MEDICAL EQUIPMENT, INC.
TERMS AND CONDDITIONS OF RENTAL AND SALES

1. Rental equipment covered by this invoice will be maintained and serviced by **Lima Medical Equipment, Inc.** Customer must give **Lima Medical Equipment, Inc.** reasonable notice that such maintenance and/or service is required.

2. **Lima Medical Equipment, Inc.** may take a special charge for after-hour. Saturday and Sunday calls for service, pickups, or deliveries requested by Customer.

3. Equipment hereby rented is at the rental rates listed on the face of this invoice. Such equipment will continue on a rental basis until retuned or purchased by Customer **Lima Medical Equipment, Inc.** will make no refund or deduction of charges for any unused portion of any rental period.

4. "H" 9 or 244 cu, ft.) oxygen cylinders are not sold but are loaned free of charge for 15 days, after which Customer agrees to pay monthly rent on these cylinders until they are returned to **Lima Medical Equipment, Inc.**

5. Compressed gas cylinders not purchased by Customer are subject to cylinder demurrage at **Lima Medical Equipment, Inc.** established rate, for all time cylinders are retained beyond an initial 15 days free loan period.

6. All rental charges, transportation charges on shipments to and receipts out-town customers special service charge and any other charge to be paid by Customer are due and payable at the offices of **Lima Medical Equipment, Inc.** If payments are not made in accordance with the terms and conditions of this invoice **Lima Medical Equipment, Inc.** may take possession of such equipment without notice.

7. A FINANCE CHARGE OF 1.5% per month which is an ANNUAL PERCENTAGE OF 18% may be made by ALL RENTAL, INC. and paid by Customer on any portion of Customer's account at the end of any month that is not paid by the 15th day of the following month. This percentage rate applies on amounts of $500.00 or less. A FINANCE CHARGE OF 66-2/3% per month which is an ANNUAL PERCENTAGE RATE OF 8% may be made on such amounts over $500.00.

8. **Lima Medical Equipment, Inc.** will not be responsible for any injury or damage resulting from the use of this equipment.

9. Customer will be responsible for any loss or damage to rental equipment from fire, theft, carelessness or any cause other than reasonable wear.

10. Customer will not move rental equipment without the written permission of **Lima Medical Equipment, Inc.**

11. Customer may purchase rental equipment at **Lima Medical Equipment, Inc.** published price applying the first rental period charge as invoices by **Lima Medical Equipment, Inc.** and paid by Customer to the purchase price equipment.

Equipment rented hereunder, remains the property of **Lima Medical Equipment, Inc.**

CAUTION OIL OR GREASE OF ANY KIND MUST NOT BE USED ON CYLINDER VALVES GAUGES REGULATORS OR OTHER FITTINGS

Lima Medical Equipment, Inc.
Ph: (305) 883-7172 * Fax: (305) 883-8911
2891 West 2nd Avenue Hialeah, Florida 33010

HOME PATIENT INSTRUCTIONS CHECK LIST
LISTA DE LAS INSTRUCCIONES PARA LOS PACIENTES EN SU HOGAR

Patient / Paciente ……

Caregiver / Persona a su cuidado ……

Equipment / Equipos ……

GOALS: Patient / Caregiver will achieve understanding of the operation and maintenance of the medical equipment.
META: El paciente / acompanante deben de entender correctamente su uso seguro y mantenimiento de los equipos medicos.

OBJECTIVES / OBJETIVOS:

( ) Comprehends the safe use of prescribed equipment.
Comprender el uso seguro de los equipos.
( ) Comprehends the cleaning and maintenance of the equipment.
Comprender el mantenimiento de los equipos y si limpieza.
( ) Understand how to resolve common problems associated with the equipment.
Comprender como resolver problemas comunes a asociados con los equipos.
( ) Understand how to obtain service.
Sabe como obtener servicio.

GENERAL /GENERAL:

( ) Caregiver is present during instructions.
Acompanante esta presente durante las instrucciones.
( ) Received equipment operating instructions and goals.
Recibo las instrucciones de operacion y objetivos de los equipos.
( ) Received patient rights and responsibilities.
Recibo los derechos y responsabilidades del paciente.
( ) Received hurricane suggestions form.
Recibo las sugerencias para huracanes.

HOME SAFETY / PRECAUCIONES EN EL HOGAR:

( ) Equipment location is acceptable.
La localizacion de los equipos es aceptable.
( ) Patient access is acceptable.
El acceso al paciente es aceptable.
( ) Checked for safety hazards in the home.
Se verifico cualquier situacion peligrosa en la casa.

FIRE SAFETY / PRECAUCIONES DE FUEGO:

( ) Smoke detector should be found in the patient's home.
Debe de haber un detector de fuego dentro de la casa del paciente.
( ) Fire extinguisher should be found in the patient's home.
Debe de haber un extinguidor de fuego dentro de la casa del paciente.

OBSERVATION / OBSERVACION:

NOTICE TO PATIENT /CAREGIVER / AVISO A LOS PACIENTES/ACOMPANANTES:

The company assumes no responsibility concerning the effectiveness of any treatment performed with this equipment. Your physical strictly defines treatment using this equipment.

La compañia no asume ninguna responsabilidad referente a la efectividad de cualquier tratamiento operado con estos equipos. El tratamiento recibido con estos equipos es estrictamente ordenado y definido por su medico.

Driver …… Date …… Patient……

Ocean Breeze Medical Equipment
2345 West 80th Street. Bay 6
Hialeah, Fl 33016
(305) 817-8177

Tenth Month Purchase Option Letter for All Capped Rental Items

You have been renting your_____
(Specify the item(s) or equipment) for 10 continuous months. Medicare requires **Ocean Breeze Medical Equipment** to give you the option of converting your rental agreement to a purchase agreement. This means that if you accept this option, you would own the medical equipment. If you accept the purchase option, Medicare continues making rental payments for your equipment for 3 additional rental months. You are responsible for the 20 percent coinsurance amounts or, for unassigned claims, the supplier's entire charge. After these additional rental payments are made, title to the equipment is transferred to you. You have until_____
(Specify the date which is one month from the date the supplier notifies the patient of the option) to elect the purchase option. If you decide not to elect the purchase option, Medicare continues making rental payments for an additional 5 rental months, or a total of 15 months. After a total of 15 rental months have been paid, title to the equipment remains with the medical equipment Supplier, however, the supplier may not charge you any additional rental amounts.
In making your decision to rent or purchase the equipment, you should know that for purchase equipment, you are responsible for 20 percent of the service charge each time your equipment is actually serviced or, for unassigned claims, the supplier's entire charge. However, for equipment that is rented for 15 months, your responsibility for such service is limited to 20 percent coinsurance on a maintenance and servicing fee payable twice per year when whether or not the equipment is actually serviced.

Supplier's Name
Ocean Breeze Medical Equipment

Option Chosen: **Purchase [ ]** **Rental [ ]**

Beneficiary's Signature **Date**

_____ _____

Ocean Breeze Medical Equipment
2345 West 80 Street Bay 6
Hialeah, F1 33016
Office (305) 817-8177
Fax (305) 817-8170
obme@netrox.net

MEDICARE BENEFICIARY COMPLAINT LOG

Date of receipt of complaint: _____

Client's name: _____

Client's address: _____

City: _____ State: _____ Zip code: _____

Client's telephone number: (____)_____-_____

Client's Medicare or Health Insurance Claim Number: _____

Description of complaint: _____

_____

_____

_____

Action taken to resolve the complaint: _____

_____

_____

_____

_____ _____

Signature of representative Date

Ocean Breeze Medical Equipment

2345 West 80 Street Bay 6
Hialeah, Fl. 33016
Office (305) 817-8177
Fax (305) 817-8170
obme@netrox.net

INCIDENT / ACCIDENT OCCURRENCE REPORT

(Use Extra Pages if Needed)

Client Occurrence: _____ Employee Occurrence: _____
Employee Name: _____ Employee SSN:_____
Client Name: _____
Client Address: _____ Phone: (____)_____
City: _____ State: _____ Zip: _____
Others Assigned: _____
Date of Occurrence: _____ Notification Date: _____
Location of Occurrence: _____ Witnesses: _____
Type of Occurrence: Describe the occurrence and how it occurred. List all people involved or aware of the occurrence: _____
_____
_____
_____

Intervention: Describe in detail how the provider bandied this occurrence i.e. MD referral, treatments, medications, Police referrals, etc. List reports, which were filed: _____
_____
_____
_____

Follow up: Describe in detail the follow-up, medical treatment, provider or police action (if applicable): _____
_____
_____
_____

Disposition: Describe in detail how this case has been resolved. If indicated, state when/if employee can return to work: _____
_____
_____

Date of resolution: _____ Date case Closed: _____
Employee's Signature: _____ Date signed: _____
Supervisor Signature: _____ Date signed: _____
Action to prevent similar occurrence: _____
_____
_____
_____

Ocean Breeze Medical Equipment
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Hialeah, Fl 33016
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Fax (305) 817-8170
obme@netrox.net

PROTOCOL FOR RESOLVING COMPLAINTS FROM MEDICARE BENEFICIARIES

The patient has the right to freely voice grievances and recommend changes in care or services without fear of reprisal or unreasonable interruption of services.

Service, equipment, and billing complaints will be communicated to management and upper management. These complaints will be documented in the *Medicare Beneficiaries* Complaint Log, and completed forms will include the patient's name, address, telephone number, and health insurance claim number, a summary of the complaint, the date it was received, the name of the person receiving the complaint, and a summary of actions taken to resolve the complaint.

All complaints will be handled in a professional manner. All logged complaints will be investigated, acted upon, and responded to in writing or by telephone by a manager within a reasonable amount of time after the receipt of the complaint. If there is no satisfactory resolution of the complaint, the next level of management will be notified progressively and up to the president or owner of the company.

The patient will be informed of this complaint resolution protocol at the time of set-up service.

_____ Client Signature

_____ Date

Ocean Breeze Medical Equipment

Acuerdo con el Cliente

Fecha: _____ Paciente: _____ Cuenta#: _____

CONSENTIMIENTO PARA RECIBIR SERVICIOS **INICIALES _____**

Yo autorizo a Ocean Breeze Medical Equipment, Inc. que rinda los apropiados servicios como recetados por mi doctor. Por este medio, libero a Ocean Breeze Medical Equipment, Inc. de toda responsabilidad que se pueda presentar.

PERMISO PARA DIVULGAR EL USO DE INFORMACION **INICIALES _____**

Por este medio doy mi consentimiento a que divulgen mi expediente medico para ser revisado por representantes autorizacdos de Medicare/Medicaid y/o mi compañia de seguros privada, para determinar mis beneficios. Entiendo que estoy en derecho legal de negar la divulgacion de mi expediente personal y medico y que por medio de la presente estoy renunciando a este derecho. Este consentimiento estara en vigor por un periodo de tiempo razonablemente necesario para el individuo/agencia solicitando revisar mi expediente clinico o hasta que yo lo revoque por escrito. Tal revocacion sera efectiva prespectivamente. Mas aun, autorizo a que periodicamente examinen mis archivos para verificar el cumplimiento de las regulaciones y requisitos.

BENEFICIOS DE SEGURO **INICIALES _____**

Por este medio, autorizo a mis seguro privado que pagen los beneficios debidos a Ocean Breeze Medical Equip. en mi nombre. Soy personalmente responsable por mi deducible, co-seguro o falta de pagos. En caso de que estos beneficios sean pagados a mi directamente, estoy de acuerdo a firmar los beneficios a Ocean Breeze Medical Equip. inmediatamente despues de recibirlos.

DERECHOS Y RESPONSABILIDADES **INICIALES _____**

Yo certifico que he recibido una copia de el informe de derechos y responsabilidades de el cliente de Ocean Breeze Medical Equipment, Inc. y a sido explicado con claridad por un representante.

GARANTIA DE EL EQUIPO **INICIALES _____**

Todo producto vendido o rentado por Ocean Breeze Medical Equipment tiene una garantia de fabrica por un (1) año. Ocean Breeze Medical Equipment, Inc. notificara a los beneficiarios de la garantia cubierta al tiempo de la entegra y honrara todas las garantias bajo la ley. Repararemos o remplazaremos, libre de cargos, todo el equipo bajo garantia. Un manual sera entregado con informacion sobre el equipo y la garantia cuando disponible. Ha sido instruido y entiendo la garantia en el producto que he recibido.

PROTOCOLOGO PARA RESOLVER QUERILLAS **INICIALES _____**

El paciente tiene derecho a dejar comentarios o querillas cuando conciderese necesario sin medio a cambios en el servicio proveido. Querillas de el servicio, equipo o cobros seran dirijidas a la gerencia. Estas querillas seran documentadas en el libro de querillas de Medicare. Todas las querillas seran tratadas en una manera profesional. Seran investigadas y las respuestas se daran por escrito o por telefono con las posibles soluciones. El paciente es informado de el protocologo de querillas al tiempo de la entrega de el equipo.

(Favor de firmar en la parte del frente, despues de haber leido esta forma)

Ocean Breeze Medical Equipment

Client Agreement

Date: _____ **Patient Name:** _____ **Patient #:** _____

CONSENT TO RECEIVE SERVICES **INITIALS** _____

I authorize Ocean Breeze Medical Equipment, Inc. to render appropriate services as prescribed by my physician. I hereby release Ocean Breeze Medical Equipment, Inc. from all liability incurred as a result of the care provided by the staff of ocean Breeze Medical Equipment, Inc.

PERMISSION FOR DISCLOSURE OF USE OF INFO. **INITIALS** _____

I consent to the release of Ocean Breeze Medical Equipment, Inc. records to be reviewed by authorized representatives of Medicare/Medicaid and/or my private insurance company for use in determining my healthcare benefits. I understand I have the legal right to refuse the release of my personal information and medical records now held by Ocean Breeze Medical Equipment, Inc. and that I am waving this legal right by signing this consent. This consent shall be valid for the period of time reasonably necessary for the individual or agency requesting to review my clinical records or until I revoke this consent in writing. Such a revocation shall be perspective effect only. I further authorize Ocean Breeze Medical Equipment, Inc. and other licensing bodies to periodically examine my records for the purpose of checking compliance to regulations and requirements.

INSURANCE BENEFITS **INITIALS** _____

I hereby authorize my private insurance carrier to pay insurance benefits to Ocean Breeze Medical Equipment, Inc. on my behalf, I will personally be responsible for my deductions, co-insurance and disallowance of payment. In the event benefits are paid directly to me I agree to immediately, upon receipt, sign them over to Ocean Breeze Medical Equipment, Inc.

CLIENT HANDBOOK **INITIALS** _____

I have received a copy of the Ocean Breeze Medical Equipment, Inc. client handbook and have had all contents discussed and explained to me. I hereby certify that I have received and read a copy of the client service agreement and have had all questions answered to my satisfaction.

EQUIPMENT WARRANTY **INITIALS** _____

All products sold or rented by Ocean Breeze Medical Equipment, Inc. Carry a one year manufacturers warranty against defects. Ocean Breeze will notify all beneficiaries of the warranty coverage and will honor all warranties under applicable law. We will repair or replace, free of charge, all covered equipment under warranty. An owner's manual with warranty information will be provided to the beneficiaries when available. I have been instructed and understand the warranty coverage in the product I have received.

PROTOCOL FOR RESOLVING COMPLAINTS **INITIALS** _____

The patient has the right to freely voice grievances and recommend changes in care or services without fear of reprisal or unreasonable service interruption. Service, equipment and billing complaints will be communicated to management. These complaints will be documented in the Medicare beneficiaries' complaint log. All complaints will be handled in professional matter, investigated, acted upon, and responded to in writing or by telephone. The patient will be informed of this complaint resolution protocol at the time of set-up service.

_____ _____

CLIENT SIGNATURE **DATE**

(Para la version de español, por favor leer la parte de atras)

Ocean Breeze Medical Equipment

2345 West 80 Street bay 6 Hialeah, Fl 33016
Office (305) 817-8177 Fax (305) 817-8170
Email obme@netrox.net

NOTICE OF PRIVACY PRACTICES.
HIPAA

Effective Day Policy: April 14.2003.

We are dedicated to protecting your right to privacy of your medical information while providing the highest quality of medical care. We want you to be aware of new regulations that affect how we use and disclose your medical information, and the rights you have regarding your medical records. New Privacy Rules adopted as part of the Federal Health Insurance Portability and Accountability Act (HIPAA) establish standards for the release of medical information that personally identifies you.

Our Privacy Practices

- We must provide you access to a Privacy Notice that explains how we may use or disclose your medical information,
- We will ask for you to acknowledge that you have received and understood our Privacy Notice.

Your Permission

- Once we have let you know about our Privacy Practices, we may release information about you for purposes of treatment, billing for services, or operational purposes without further permission from you.

Your Rights Regarding Your Medical Records

The Federal Privacy Regulations give you many rights regarding your medical records. They include:

- The right to an accounting of certain disclosures of your medical information in the six years prior to the date of your request.
- The right to Inspect and obtain a copy of your medical information.
- The right to receive confidential communications of your medical information.
- The right to receive confidential communications by an alternative means at an alternative location.
- The right to request an amendment to your medical record.
- The right to submit a complaint to our company about how your medical information is used or disclosed.

Patient Signature (For Spanish version please read the back of this form) Date

Ocean Breeze Medical Equipment

2345 West 80 Street bay 6 Hialeah, Fl 33016
Office (305) 817-8177 Fax (305) 817-8170
Email obme@netrox.net

BOLETIN SOBRE LAS PRACTICAS DE PRIVACIDAD HIPAA

La Poliza Entra en Efecto en Abril 14, 2003.

Nuestra organización está dedicada a proteger los derechos de privacidad que tiene usted sobre su información médica, mientras le proveemos el mejor cuidado médico. Queremos que usted esté informado de las nuevas regulaciones que van a estar en efecto a partir del día 14 de Abril del 2003. Estas regulaciones afectan la manera en como se utiliza su información médica y sobre todo que derechos tiene usted con relación a su expediente médico. Las nuevas regulaciones de Privacidad adoptadas como parte de HIPAA establecen criterios para poder entregar o revelar información médica que lo identifique a usted personalmente.

Nuestras Prácticas de Privacidad

- Nuestra facilidad le tiene que proveer acceso a nuestra Práctica Privada,la cual le explica en detalle como nosotros utilizamos su información médica y con quien compartimos su información médica.
- Nosotros le pedimos que cuando usted reciba esta información firme este papel dando por entendido que le fue explicado a usted en su totalidad como es el funcionamiento de nuestras prácticas de Privacidad y que usted las ha entendido.

Con su Autorización

- Después que le hallamos explicado acerca de nuestras Prácticas de Privacidad, nosotros pademos utilizar su información médica con relación a su tratamiento, para sevicios de cobro o para nuestro, proceso operacional sin requerir autorización suya adicional.

Sus Derechos con Relación a su Expediente Médico

Las Regulaciones Federales de Privacidad le dan a usted muchos derechos con relación a su expediente médico. Estos derechos incluyen:

- El derecho a una contabilidad de ciertas revelaciones de su información médica hasta seis años de antelación a su pedido de contabilidad.
- El derecho de inspeccionar y obtener una copia de su información médica.
- El derecho de recibir comunicación confidencial de su información médica.
- El derecho de recibir una comunicación confidencial por medio de una forma alterna y en una localización alterna.
- Ell derecho de solicitar una enmienda a su expediente médico.
- El derecho de someter quejas a nuestra compañía con relación al manejo de su información médica y como ha sido utilizada o revelada.

(Favor de firmar en la parte del frente, después de haber leído esta forma)

Ocean Breeze Medical Equipment, Inc.

24 NE 167th Street, Miami, FL 33162
Office (305) 956-9720 Fax (305) 956-5860
Email: obme@netrox.net

INFORMATION FOR OUR CLIENTS

ELIGIBILITY:

To be eligible for care, clients must be referred by their private physician, requesting Home Medical Equipment. All services provided must meet requirements of AHCA guidelines. To initiate care for a client, a physician must sign and return the order form within 10 days to our office at the address above.

EMERGENCY:

If you have an emergency please call **911**
In case you need to contact a staff member, please call (305) 956-9720

ABUSE OR NEGLECT:

This letter is written to you from this office, in good faith and the purpose of it is to inform you that under Florida Statutes, you have the right to report any acts against you if such acts constitute abuse, neglect or exploitation.

In any case every case where an employee of this company, in the course of his/her normal duty, is involved in any act that constitutes abuse, neglect or exploitation, we urge you to call our office immediately (305) 956-9720. You should also call the abuse registry Hotline at their toll free number 1(800) 96 ABUSE (962-2873)

TO REPORT ABUSE, NEGLECT OR EXPLOITATION

CALL TOLL FREE

1 (800) 96 ABUSE (962-2873)

Ocean Breeze Medical Equipment
2345 West 80th Street Bay 6
Hialeah, Fl 33016
Office (305) 817-8177
Fax (305) 817-8170
obme@netrox.net

EQUIPMENT WARRANTY INFORMATION FORM

Every product sold or rented by our company carries a 1 year manufacturer's warranty.

Ocean Breeze Medical Equipment will notify all Medicare beneficiaries of the warranty coverage, and we will honor all warranties under *applicable law.*

Ocean Breeze Medical Equipment *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

OCEAN BREEZE MEDICAL EQUIPMENT INC.

WOUND RECORD

Addendum to Nurse's Note

PATIENT: _____ CR#: _____

Week of: _____ to _____

Date	CURRENT WOUND CARE *(changes require MOD order)*

WOUND DESCRIPTION, measurements are: cm or mm" *(circle one)*

Location	L	W	D	U or T	Appearance	Drainage: Amt. Color/Odor	Surrounding Skin
#1							
#2							
#3							
#4							

KEY: L - length *W - width* D - *depth* *U - undermining* *T - tunnelling*

Date	Change in description of wound and additional pertinent information: (sensation, physician intervention sutures, deterioration, location of undermining and/or tunneling, date of debridement, culture, etc.)

Signature: _____ Date: _____