Office (800) 684-0299

Fax (818) 713-0879

Apguard Medical Inc.

Financial Policy

Thank you for choosing Apguard Medical Inc. We are committed to treating our customers in a professional and caring manner. This is a statement of our financial policy that defines the customer's financial responsibility to us and which we require the patient (or legal guardian or parent) to read and sign before we can render any services.

Eligibility and Financial Responsibility
Please be aware that the insurance company will only cover services that they consider eligible and only for the length of time that they determine. It is the patient's responsibility to find out what their eligibility for services is. If we provide services that a doctor ordered, but the insurance company deems the patient's coverage does not provide eligibility, the patient will be financially responsible to pay for those services. Our Customer Service staff will be glad to assist in determining the financial responsibility for services in advance if the patient consults with them. The insurance company determines the actual coverage/eligibility. When the insurance company reviews the claim the patient may be required to make additional payments to Apguard Medical Inc., to pay for what the insurance does not cover.

Insurance Changes
It is *the patient's* responsibility to inform us of any changes to the policyholder's insurance policy. Should the insurance coverage change or should the patient change insurance companies, the authorization for coverage of services may become invalid. In that event, the patient will become responsible for all charges for services rendered. If the insurance does change, please call our office immediately and let us help you understand what may be needed to maintain insurance coverage for our services.

Authorization
Most HMO insurances require that the patient attain prior authorization for services from the Medical Group or Physician before they will pay. Although there may be an authorization, this is not a guarantee of payment or may only be for a specific product for a specific amount of time. If there is no authorization and the patient requests that services or products are still provided, payment will be required in full.

Equipment and Supplies
We endeavor to always deliver equipment that is in good working order. If it is not, it is the patient's responsibility to notify us immediately so that we can remedy the problem in a timely manner. All equipment is considered to be on a month-to-month rental and is expected to be returned undamaged at the end of the rental period. Any loss or damage of equipment during the time that it is out on rental will be the patient's financial responsibility. Equipment is not considered *purchased* until it has been paid for *in full* and until such time, it remains the property of Apguard Medical Inc. After being paid in full, all equipment purchased in whole or in part by the insurance company will have the title of ownership transferred to the insurance beneficiary. The patient will then become responsible for its maintenance and repair costs. All supplies are considered non-returnable items. Our return policy for supplies and/or purchased equipment is that they must be returned unused within 3 days of delivery to avoid a restocking and/or pick up fee. Please contact us to request a detailed copy of our return policy.

Minor Patients
The legal guardian and/or parents of a minor receiving equipment and services from Apguard Medical Inc. are responsible for full payment of services that insurance does not cover.

Interest and Collection Penalties
Account balances unpaid within 30 days of receipt are subject to late fees based on a rate of 15% per annum. Unpaid account balances exceeding 90 days from the date of receipt will be subject to external collection efforts contracted by Apguard Medical Inc.

Signature for Assignment of Benefits And Signature for Release of Medical Information
I the undersigned have read, understand and agree to the financial responsibilities in this agreement for services with Apguard Medical Inc. I approve and agree to sign over to Apguard Medical Inc. payment of all monies that I receive from my insurance company for any medical equipment and/or supplies provided to me by Apguard Medical Inc. I also understand that Apguard Medical Inc. will submit bills directly to my insurance company and, when appropriate, make an asserted effort to obtain reimbursement on behalf of the patient for services rendered by Apguard Medical Inc.

I the undersigned also authorize any holder of medical information and/or my insurance company to release my medical records to Apguard Medical Inc. for the purposes of determining appropriate care, benefits, and payments. I further authorize Apguard Medical Inc. and/or the Joint Commission for the Accreditation of Health Care Organizations, JCAHO, to periodically examine any records for the purpose of quality improvement of service. I permit a copy of this authorization to be used in place of the original.

X _____ _____ _____ _____

Signature of Patient or Legally Responsible Guardian | Date | Printed Name | Account #