PULMONARY PROVIDERS GROUP, INC.

4330 N. California Ave # A • Chicago, Illinois 60618 • **Office 847.824.0500**
24 Hour Service 847.226.3049 • Fax 847.824.0529 • Toll Free 877.214.0400

PATIENT / CLIENT AGREEMENT

Request for Provision of Services: I understand that by signing this agreement, I indicate my wish to rent or purchase health care products or services or both from PULMONARY PROVIDERS GROUP, INC.

Indication of Medical Responsibility: I understand that I am under the supervision and control of my attending physician. I also understand that my physician has prescribed the therapy noted as part of my treatment. I understand that PULMONARY PROVIDERS GROUP, INC. services do not include prescriptive or other functions typically performed by licensed physicians, and that my physician is solely responsible for diagnosing and prescribing drugs and therapy for my condition and otherwise supervising and controlling my medical care.

Agreement to Pay: Inconsideration of PULMONARY PROVIDERS GROUP, INC., undertaking to supply patient with any products and services ordered by patient or on behalf of patient, the undersigned patient, spouse, guarantor and/or guardian agree that each of them is responsible for payment to PULMONARY PROVIDERS GROUP, INC. for all such products and services provided to patient. In addition, I/we understand that the monthly balance due will be approximately ___20%____. I agree to pay the balance due in full upon receipt of an invoice. If payment is not made, I understand that PULMONARY PROVIDERS GROUP.INC. will pursue its normal collection policy.

Release of Information: The undersigned authorize our insurer(s) and any other third party payor who provides patient with coverage to disclose to PULMONARY PROVIDERS GROUP, INC. any information regarding such coverage, including but not limited to payments made by such insurer(s) or third party payor (s) to any of us, for home therapy rendered to patient by PULMONARY PROVIDERS GROUP, INC. and the scope and extent of coverage available from time to time. Patient authorizes all medical personnel to provide information to PULMONARY PROVIDERS GROUP INC, Inc. concerning his/her medical history, as it may relate to patient's home therapy. Patient authorizes PULMONARY PROVIDERS GROUP, INC. to release any pertinent medical or claims information to any third party requestor as; it pertains to patient's home therapy and service.

Grievance Reporting: I acknowledge that I have been informed of the procedure to report a grievance should I became dissatisfied with any portion of my home care experience. I understand that I may lodge a complaint without concern for reprisal, discrimination, or unreasonable interruption of service. To place a grievance, please call 847-824-0500 and speak to the supervisor. I will receive oral or written confirmation from the supplier within five (5) calendar days from date of supplier receiving the complaint stating that the supplier has received the complain and began the investigation process. I'll be notified in writing about the results of supplier's investigation and response within fourteen (14) days.

Client / Patient Handouts: I acknowledge that I have received a copy of the Client/patient Handouts, which contains Client/patient rights and Responsibilities, Supplier Standards, Home Safety Information, HIPPA Privacy Standards, Emergency Planning, and Advance Directive Information. I acknowledge that the information in the Client/patient Handouts has been explained to me and that I understand the information. I understand my right to formulate and to issue Advance Directives to be followed should I became incapacitated. I will furnish PULMONARY PROVIDERS GROUP, INC. with a copy of such documents.

I request payment under the Medical Insurance Part of MEDICARE or other insurance carriers be made directly to PULMONARY PROVIDERS GROUP, INC. for service furnished to me during the effective period of this authorization. I understand that I am responsible for the deductible co-insurance and non-covered services. This authorization may be cancelled by mutual agreement of the provider and customer at any time by written notice to the Medicare Carrier.

I have read and fully understand the above information pertaining to the Patient Agreement.