Medical Service Company

ACCEPTANCE OF BILLING & COLLECTION POLICIES AND ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

Insurance is not a guarantee of payment; it often does not cover all costs. Insurance benefits are determined by governmental agencies and/or your employer, not the provider of service. Your insurance policy is a contract between you and your insurance company. Medical Service Company is not a third party to that contract, therefore knowing your insurance coverage and benefits is your responsibility. As a courtesy, we will file a claim on your behalf if you present valid insurance information. However, you will be expected to pay for services rendered if we are unable to verify insurance coverage.

1. **AutoPay:** If payment account information is provided to a representative of Medical Service Company over the phone, in person, or through our patient portal, you expressly authorize Medical Service Company to enroll that payment account in AutoPay. When enrolled in AutoPay, we will automatically electronically debit your payment account for any subsequent amounts due. You will receive advance notification of the amount to be withdrawn and electronic debit date after such claim(s) have been processed by your insurance company, if applicable. To learn more about AutoPay, and/or to set up an account in our patient portal, please visit https://medicalserviceco.hmebillpay.com.

2. **Financial Estimates:** Any amount indicated on delivery tickets or communicated to you over the phone or in person by a representative of Medical Service Company is an estimate based upon information available to us through your insurance at the time of communication. Such estimates may differ from actual charges after your insurance has processed such claim(s). Please reach out to your insurance provider should you want additional information. Please monitor all correspondence from Medical Service Company and your insurance provider to know exact charges.

3. **Authorization to Convert your Check to an Electronic Funds Transfer Debit:** Unless expressly disallowed on your check, you authorize your bank account to be electronically debited for the check amount plus any applicable fees. The use of a check for payment is your acknowledgment and acceptance of this policy and its terms and conditions.

4. **Late Fees/Returned Checks:** A late fee will be assessed for past due service charges. Returned checks, for any reason, will result in a $25.00 returned check fee.

5. **Return Policy:** Unopened supplies may be returned within 30 days of purchase. Enteral supplies cannot be returned or exchanged. Rental equipment may be returned at any time. We do not prorate rental amounts. If rental equipment is not returned prior to the monthly rental date anniversary, we will bill for such rental month in full to you and your insurance, if applicable, and any related deductible, co-pay, or non-covered amounts are owed in full by you.

6. **Insurance and/or Residential Changes:** It is the patient's responsibility to inform Medical Service Company of any insurance and/or residential changes and to be in compliance with all insurance requirements. Failure to notify Medical Service Company of these changes and failure to maintain compliance will result in the patient being responsible for any services not paid by your insurance at retail prices, unless prohibited by law or policy. Residential changes include, but are not limited to, admission to a skilled nursing facility or other health care facility, as well as moving outside of our geographic area.

7. **Network Provider:** It is the patient's responsibility to determine if Medical Service Company is an in-network provider with your insurance company. Any financial estimates provided to you may be based on in-network coverage rates which may not be applicable if Medical Service Company is not a participating provider.

8. **Covered Items:** It is the patient's responsibility to know what items are covered by their insurance company's benefit plan. While equipment and supplies may be "covered" by your insurance, you may still have an out-of-pocket expense due to your deductible not being met at the date(s) of service, having a copay in connection with your insurance policy, or not following insurance guidelines. While we may provide estimates of deductible or co-pay amounts based upon information available to us from your insurance provider at the time of communication, it is your responsibility to know whether your deductible has been met and what your co-pay amount or percentage is.

9. **Therapy Requiring Compliance:** Your insurance may require usage data to be transmitted to them to prove compliance. In the event that you do not meet such compliance criteria and your insurance will no longer cover your equipment, you are required to return your equipment within the specified time frame communicated to you or purchase it at a price up to minimum advertised prices established by manufacturers, unless prohibited by law or policy. You will be responsible for payment of rental months not covered by insurance until equipment is returned and may be subject to a restocking fee.

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10. **Rent to Own Equipment:** Any equipment on the Delivery Receipt noted as "Rental" in the "Type" column is equipment that is owned by Medical Service Company. However, many insurances will "rent to own" such equipment when after a certain period, the equipment becomes patient owned. Any "rent to own" period communicated by Medical Service Company to you for such equipment is an estimate based upon information available to us by your insurance company at the time of communication. Changes including, but not limited to, a change to your insurance can affect and, in some cases, restart, your rental period.

    For Capped rental items Medicare will pay a monthly rental fee for a period not to exceed 13 months, after which ownership of the equipment is transferred to the Medicare beneficiary. After ownership of the equipment is transferred to the Medicare beneficiary, it is the beneficiary's responsibility to arrange for any required equipment service or repair. Examples of this type of equipment include hospital beds, wheelchairs, and continuous airway pressure (CPAP) devices.

    Inexpensive or routinely purchased items can be purchased or rented; however, the total amount paid for monthly rentals cannot exceed the fee schedule purchase amount. Examples of this type of equipment include canes, walkers, crutches, commode chairs and home blood glucose monitors.

11. **Lost/Stolen/No Longer Usable Equipment:** Any equipment on the Delivery Receipt noted as "Rental" in the "Type" column is equipment that is owned by Medical Service Company. Should the equipment be lost, stolen or is no longer usable due to an issue not covered by your medical insurance, you agree to reimburse Medical Service Company for the equipment's replacement cost plus any applicable taxes, shipping and delivery costs incurred by Medical Service Company, in addition to any remaining months in the rental period. Medical Service Company does not bill home or auto insurance for lost or damaged equipment.

12. **Phone Calls/Text Messages:** You may receive autodialed, pre-recorded calls, text messages and/or email messages, from or on behalf of Medical Service Company at the telephone, wireless number(s) and email address(es) previously provided. Such communication may include information related to your treatment, information about Medical Service Company and/or marketing communications. You consent to receiving future calls or text messages at those number(s) by autodialed calls, pre-recorded calls, text messages and/or emails, and understand that your consent to such calls, text messages and emails is not a condition of purchasing any goods or services and that you may opt out of such communication at any time.

13. **Contact Information:** For questions, please call the Billing Department 440-735-3246.