Client bill of rights and responsibilities

Graymark Healthcare (GRMH) believes that you, the patient, are entitled to be treated with dignity and respect.

As a patient you should be entitled to participate in your plan of care and to make informed decisions regarding your continued care. In order for us to insure this occurs, we provide you with the following rights as a patient. The staff of GRMH is dedicated to providing the highest quality of patient care available in our industry. Our philosophy is simple, provide the level of service we, ourselves, would expect. To accomplish quality patient care; we must work together as a team. This team includes not only the employees of GRMH, but the patients and our referral sources as well. We depend upon our patients and referral sources to evaluate our performance whether good or bad. There are numerous companies in this field that can provide the same equipment; we strive to provide quality care along with state of the art equipment.

We will provide service without regard to race, creed, gender, age, handicap, religion, sexual orientation, or veteran status. You have the right to have information regarding the services, products, and equipment provided to you or available for you. Simply ask our customer service department or your service technician for information concerning other items we can provide to you. You have the right to receive services in a timely and consistent manner. Information is to be provided to educate you on the proper use of your equipment. You may contact us toll free at (877) 440-4263 seven days a week. A representative will be available to assist you 24 hours a day. If your care is being provided through hospice, your charges will be sent directly to the hospice. If the hospice authorized the services, they should be responsible for the charges and you will not receive a bill. If your care is being provided through Medicare, your charges will be sent directly to Medicare for payment. A portion of the charges should be covered and you, the patient, are responsible for the remainder; unless there is additional insurance coverage involved. For Medicaid, coverage should be 100% as long as you qualify. If your care is being provided through a private insurance, your insurance policy will control as to what portion you, the patient are responsible for, each plan is different so make certain to check with your specific plan.

If there are any changes to your particular billing situation we will contact you as soon as we are made aware of any changes. Likewise, you are responsible for notifying us of any changes to your insurance situation. Please be advised that ultimately you are financially responsible for the services provided. You will receive an itemized bill for any charges you are financially responsible for. You should expect all persons involved in your care to identify themselves, by name and organization. They should explain to you the nature and purpose of the service to be provided. You have the right to participate in your plan of care, in the beginning, and during its implementation. You are responsible for following this plan and providing accurate information concerning your health.

continued >>

- **You have the right to make informed decisions regarding your care and receive information in a manner that is understandable.**
- **You have the right to refuse treatment and to be informed of the potential results and/or risks.**
- **You have the right to be referred to another organization if you desire or if this organization is unable to meet your needs. You will not receive any treatment from this organization that is experimental.**
- **You have the right to be free from any mental, physical abuse, neglect, or exploitation of any kind.**
- **You have the right to have protective services offered to you.**
- **You have the right to prepare advance directives (means to communicate your wishes regarding medical treatment in the event you cannot communicate your wishes.) We will provide advance directive forms upon your request to our Customer Service Supervisor. Services will be provided based upon those directives.**
- **Our entire staff strives to provide you with excellent care and services, if we fail to provide this, please do not hesitate to let us know. You may contact our main office and ask to speak to the Customer Services Supervisor (for patient care issues), Accounts Receivable Supervisor (for billing issues) or the Office Manager.**
- **You have the right to register a complaint about care or treatment with the State, Medicare, Center for Medicare and Medicaid Services, and The Joint Commission.**
- **You have the right to have a grievance documented, and receive a response regarding the investigation and resolution of your request.**
- **You have the right to confidentiality of your records and to obtain this information within a reasonable time frame.**

We do not share this information with any entity, other than to the extent necessary to obtain reimbursement for the services we provide. The services we provide should make you more comfortable, but it will not cure any illness you might have. This equipment is not to replace any required visits to your physician. The employees of GRMH are not physicians; therefore we cannot take the place of your physician and cannot change or alter their orders. You are required to notify GRMH for the following changes: your address changes, your insurance information changes or your physician changes. All equipment is for your specific use. Please do not share this equipment with others. This equipment is not to be operated by minors (unless prescribed to them) and should be kept secure in their presence.

This equipment is not considered life sustaining; if a serious health problem results you must contact your physician or emergency services immediately.

Privacy notice

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

This Privacy Notice is being provided to you as a requirement of federal law, the Health Insurance Portability and Accountability Act (HIPPA). This Privacy Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information in some cases. Your "protected health information" means any written and oral health information about you, including demographic data that can be used to identify you. This is Health information that is created or received by your health care provider, and that related to your past, present, or future physical or mental health conditions.

1. Uses and Disclosures of Protected Health Information.

The facility may use your protected health information for purposes of providing treatment, obtaining payment for treatment, and conducting health care operations. Your protected health information may be used or disclosed only for these purposes unless the facility has obtained your authorization or the HIPPA privacy regulations or state law other-wise permits the use or disclosure. Disclosures of your protected health information for the purposes described in this Privacy Notice may be made in writing, orally or by facsimile.

A. Treatment - We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party for treatment purposes. For example, we may disclose your protected health information to a laboratory to order a blood test. We may also disclose protected health information to physicians who may be treating you or consulting with Graymark Healthcare with respect to your care. In some cases, we may also disclose your protected health information to an outside treatment provider for purposes of the treatment activities of the other providers, such as a sleep lab center.

B. Payment - Your protected health information will be used, as needed, to obtain payment for the services that were provided. This may include certain communications to your health insurance company to get approval for the visit or procedure that we have scheduled. For example, we may also disclose protected health information to your health insurance company to determine whether you are eligible for benefits or whether a particular service is covered under your health plan. In order to get payment for the services we provided to you, we may also need to disclose your protected health information to your health insurance company to demonstrate the medical necessity of the service or, as required by your insurance company, for utilization review. We may also disclose client information to another provider involved in your care for the other provider's payment activities.

C. Operations - We may use or disclose your protected health information, as necessary, for our own health care operations to facilitate the function of the facility and to provide quality care to all clients. Health care operations included such activities as: quality assessment and improvement activities, employee review activities, training programs, including those in which students, trainees, or practitioners in health care learn under supervision, accreditation, certification, licensing or credentialing activities, review and auditing, including compliance review, medical reviews, legal services and maintaining compliance programs, business management, and general administrative activities. In certain situations, we may also disclose client information to another provider or health plan for their health care operations.

II. Uses and Disclosures Beyond Treatment, Payment and Health Care Operations Permitted Without Authorization or Opportunity to Object.

Federal privacy rules allow us to use or disclose your protected health information without your permission or authorization for a number of reasons including the following:

A. When Legally Required - We will disclose your protected health information when we are required to do so by any federal, state or local law.

continued >>

B. When There are Risks to Public Health - We may disclose your protected health information for the following public activities and purposes:

- To prevent, control, or report disease, injury or disability as permitted by law.
- To report vital events such as birth or death as permitted or required by law.
- To conduct public health surveillance, investigations and interventions as permitted or required by law.
- To notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease as authorized by law.
- To report to an employer information about an individual who is a member of the workforce as legally permitted or required by law.

C. To Report Suspended Abuse, Neglect or Domestic Violence - We may notify government authorities if we believe that a client is the victim of abuse, neglect or domestic violence. We will make this disclosure only when specifically required or authorized by law or when the client agrees to the disclosure.

D. To Conduct Health Oversight Activities - We may disclose your protected health information to health oversight agency for activities including audits, civil, administrative, or criminal investigations, proceeding or actions, inspections, licensure or disciplinary actions, or other activities necessary for appropriate oversight as authorized by law. We will not disclose your health information under this authority if you are the subject of an investigation and your health information is not directly related to your receipt of health care or public benefits.

E. In Connection with Judicial and Administrative Proceedings - We may disclose your protected health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by state law. If we receive satisfactory assurances that you have been notified of the request or that an effort was made to secure a protective order.

F. For Law Enforcement Purpose s- We may disclose your protected health information to a law enforcement official for law enforcement purposes as follows:

- As required by law for reporting or certain types of wounds or other physical injuries.
- Pursuant to court order, court-ordered warrant, subpoena, summons or similar process.
- For the purpose of identifying or locating a suspect, fugitive, material witness or missing person.
- Under certain limited circumstances, when you are the victim of a crime.
- To a law enforcement official, if the facility has a suspicion that your health condition was the result of criminal conduct.
  - In an emergency to report a crime.

G. To Coroners, Funeral Directors, and for Organ Donations - We may disclose protected health information to a coroner or medical examiner for identification purposes, to determine cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaver, organ, eye or tissue donation purposes.

H. For Research Purposes - We may use or disclose your protected health information for research when the use or disclosure for research has been approved by an institutional review board that has reviewed the research proposal and research protocols to address the privacy of your protected health information.

I. In the Event of a Serious Threat to Health or Safety - We may, consistent with applicable law and ethical standards of conduct, use or disclose your protected health information if we believe, in good faith, that such use or disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

J. For Specified Government Functions - In certain circumstances, federal regulations authorize the facility to use or disclose your protected health information to facilitate specified government functions relating to military and veterans activities, national security and intelligence activities, protective services of the president and others, medical suitability determinations, correctional institutions, and law enforcement custodial situations.

continued >>

K. For Worker's Compensation - The facility may release your health information to comply with worker's compensation laws or similar programs.

III. Uses and Disclosures Permitted without Authorization but with Opportunity to Object

We may disclose your protected health information to your family member or a close personal friend if it is directly relevant to the person's involvement in your care or payment related to your care. We can also disclose your information in connection with trying to locate or notify family members or others involved in your care concerning your locations condition or death. You may object to these disclosures. If you do not object to these disclosures or we can infer from the circumstances that you do not object or we determine, in the exercise of our professional judgment, that it is in your best interests for us to make disclosure of information that is directly relevant to the person's involvement with your care, we may disclose your protected health information as described.

IV. Uses and Disclosures with you Authorize

Other than as stated above, we will not disclose your health information without your written authorization. You may revoke your authorization in writing at any time except to the extent that we have taken action in reliance upon the authorization.

V. Your Rights

You have the following rights regarding your health information:

A. The Right to Inspect and Copy your Protected Health Information - You may inspect and obtain a copy of your protected health information that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the facility use for making decisions about you.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to a law that prohibits access to protected health information depending on the circumstances, you may have the right to have a decision to deny access reviewed.

We may deny your request to inspect or copy your protected health information if, in our professional judgment, we determine that the access requested is likely to endanger your life or safety of that of another person, or that it is likely to cause substantial harm to another person referenced within the information. You have the right to request a review of this decision.

To inspect and copy your medical information, you must submit a written request to the Privacy Officer whose contact information is listed on the last page of this Privacy Notice. If you request a copy of your information, we may charge you a fee for the cost of copying, mailing or other cost incurred by us in complying with your request.

Please contact our Privacy Officer if you have questions about access to your medical records.

B. The Right to Request a Restriction on Use and Disclosures of your Protected Health Information - You may ask us not to use or disclose certain parts of your protected health information for the purposes of treatment, payment or health care operations. You may also request that we not disclose your health information to family members or friends who may be involved in your care or for notification purposes as described in this Privacy Notice. Your request must state the specific restriction requested and to whom you want the restriction to apply.

The right is not required to agree to a restriction that you may request. We will notify you if we deny your request to a restriction. If the facility does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. Under certain circumstances, we may terminate our agreement to a restriction. You may request a restriction by contacting the Privacy Officer.

continued >>

C. The Right to Request to Receive Confidential Communications From us by Alternative Means or At an Alternative Location - You have the right to request that we communicate with you in certain ways. We will accommodate reasonable requests. We may condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will require you to provide an explanation of your request. Requests must be made in writing to our Privacy Officer.

D. The Right to Request Amendments to Your Protected Health Information - You may request an amendment of protected health information about you in a designated records set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Requests for amendment must be in writing and must be directed to our Privacy Officer. In this written request, you must also provide a reason to support the requested amendment.

E. The Right to Receive as Accounting - You have the right to request an accounting of certain disclosures or your protected health information made by the facility. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Privacy Notice. We are also not required to account for disclosures that you requested, disclosures that you agreed to by signing an authorization form, disclosures for a facility directory, to friends or family members involved in your care, or certain other disclosures we are permitted to make without your authorization. The request for an accounting must be made in writing to our Privacy Officer. The request should specify the time period sought for the accounting. We are not required to provide an accounting for disclosures that take place prior to April 14, 2003. Accounting request may not be made for periods of time in excess of six years. We will provide the first accounting you requested during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee.

F. The Right to Obtain a Paper Copy of this Notice - Upon request, we will provide a separate paper copy of this notice even in you have already received a copy of the notice or have agreed to this notice electronically.

VI. Our Duties

The facility is required by law to maintain the privacy of your health information and to provide you with this Privacy Notice of our duties and privacy practices. We are required to abide by terms of this Notice as may be amended from time to time. We reserve the right to change the terms of this Notice and make the new Notice provisions effective for all future protected health information that we maintain. If the facility changes its Notice, we will provide a copy of the revised Notice upon your first visit after the change is effective.

VII. Complaints

You have the right to express complaints to the facility and to the Secretary of Health and Human Services if you believe that your privacy rights have been violated. You may complain to the facility by contacting the facility's Privacy Officer verbally or in writing. We encourage you to express any concerns you may have regarding the privacy or your information. You will not be retaliated against in any way for filing a complaint.

VIII. Contact Person

The facility's contact person for all issues regarding client privacy and your rights under the federal privacy standards is the Privacy Officer. Information regarding matters covered by this Notice can be requested by contacting the Privacy Officer. If you feel that your privacy rights have been violated by the facility you may submit a complaint to our Privacy Officer.

IX. Effective Date

This Notice is Effective April 14, 2003.

Authorization for uses and disclosures of protected health information

Name: ______________________________ DOB: ______________

Social Security: ________ - _________ - ________ Phone: ______________________

E-mail address: ______________________________

1. I authorize Graymark Healthcare, to release or disclose my medical record.
2. I authorize the release of the indicated sensitive records:

☐ Mental Health diagnosis or treatment ☐ Drug and alcohol abuse, diagnosis, treatment

☐ HIV or AIDS testing information ☐ Genetic testing information

3. Disclose records to: PLEASE WRITE IN THE NAMES OF DESIGNATED PERSON(S)

☐ Spouse: ______________________________ (Initial) __________

☐ Father: ______________________________ (Initial) __________

☐ Mother: ______________________________ (Initial) __________

☐ Other: ______________________________ (Initial) __________

5. This authorization shall be in effect for 12 months following the date of signature.

6. I understand that protected health information released pursuant to this authorization may be re-disclosed by the recipient(s) on this form to other individuals or organization that are not subject to privacy protection laws. I understand that if I have received care from another facility on behalf of Graymark Healthcare the records of that treatment are part of my medical record, Graymark Healthcare will include it as part of the release. I also hereby release Graymark Healthcare from all legal responsibilities and liabilities that may arise from the release of information.

7. I understand that Graymark Healthcare may not condition my treatment for payment of my bills on my decision to sign this authorization.

8. I may revoke this authorization at any time, provided I do so in writing and submit it to Graymark Healthcare. The revocation will take effect when Graymark Healthcare receives it, except to the extent that Graymark Healthcare or others have already relied on it.

9. A photocopy is as valid as the original.

Signature of Patient or Guardian: ______________________________ Date: __________

Relationship to patient if unable to sign: ______________________________

Witness: ______________________________ Date: __________

Graymark Healthcare is committed to partnering with patients and physicians to promote and provide excellence in sleep medicine.

For information on sleep apnea or sleep testing clinics, visit: **www.graymarkhealthcare.com**

Sleep better, live longer.℠

Info@GRMH.com | GraymarkHealthcare.com

New patient intake evaluation

(Do not leave any blank spaces)

Referral Information:

Patient: ______________________________ Patient ID: ______________

DOB: ______________________________ Email: ______________________________

Referring Physician: ______________________________

Phone: ______________________________ Fax: ______________________________

Orders: ______________________________

____

Related Medical History from referring Physician and/or Sleep Clinic Provider: ______________________________

____

Concurrent treatments or medical equipment: ______________________________

____

Mandatory Infection Control Data Collection:

Does the client report or exhibit any type of infection (airborne, blood borne, or other?) Please explain.

____

____

Functional Assessment Observations and Review with Patient

Ambulation: ☐ Normal ☐ Impaired / Comments: ______________________________

Motor Control: ☐ Normal ☐ Impaired / Comments: ______________________________

Cognitive: ☐ Normal ☐ Impaired / Comments: ______________________________

Hearing: ☐ Normal ☐ Impaired / Comments: ______________________________

Vision: ☐ Normal ☐ Impaired / Comments: ______________________________

Psycho/Social: ☐ Normal ☐ Impaired / Comments: ______________________________

Other: ______________________________

Referred back to physician? ______________________________

Referred to Community Agency? ______________________________

continued >>

Graymark Healthcare is committed to partnering with patients and physicians to promote and provide excellence in sleep medicine.

For information on sleep apnea or sleep testing clinics, visit: **www.graymarkhealthcare.com**

Sleep better, live longer.℠

Info@GRMH.com | GraymarkHealthcare.com

Patient Education Checklist (place check mark after completed)

______ Patient was provided oral and written instructions to operate machine.

______ Patient was given oral and written infection control/cleaning instructions.

______ Patient or caregiver demonstrates ability to correctly place mask on self.

______ Patient or caregiver demonstrates ability to operate machine independently.

______ Patient was given opportunity to ask questions and is satisfied with explanation.

______ Patient was informed of warranty information (oral and written).

______ Patient was informed of how to reach GRMH if needed after hours.

______ Patient informed how to re-order supplies.

______ Patient and technician are confident that the machine meets the patient's needs.

______ Patient was informed that GRMH will contact them within 2 business days to help them with any issues related to the new equipment or its use.

Contact Information:

The best phone number to reach the patient during the day is: ____

The best time to call during the day is: __________________________

Patient Goals:

1. Patient will successfully use the CPAP.
2. Patient will achieve improvement in sleep quality.
3. ____
4. ____

Tech name: ____

Tech Signature: ____ Date: __________________

Patient name: ____

Patient Signature: ____ Date: __________________

Please fax completed form to referring physician and document in chart. Make copy for patient.

Agreement

Patient Name: ____ Date of Birth: ________________________

Set-up Date: _________________________

Agreement to Pay/Bill

I, __________ (initial) request that Graymark Healthcare (GRMH) provide any home therapy products prescribed by my attending physician. In consideration of GRMH undertaking to supply patient with products ordered by patient or on behalf of patient, the undersigned Patient, Spouse, Guarantor/Guardian and/or Insurance Subscribers/Policy Holder agree that each of them are responsible for payment to GRMH, for all products provided to patient.

Assignment of Rights

I hereby assign GRMH (to the extent allowed by law), the right to collect unpaid insurance benefits, penalties, attorneys fees, court cost and all other recoverable damages of any nature from the medical insurance company that provides coverage on the date listed above.

Release Medical Information

The undersigned authorizes our insurer(s) and any other third party payer who provides patient with coverage to disclose to GRMH, any information regarding such coverage, including payments made by such insurer or third party payer to any of us, for home therapy rendered to patients by GRMH.

I request that payment of benefits be paid to GRMH for any products furnished to me by GRMH. I authorize the release of any necessary medical information to determine these benefits or the benefits payable for home therapy products. I request that payment of authorized insurance benefits be made whether to me or on my behalf to GRMH, for any home therapy products furnished to me by GRMH. I authorize any holder of medical information about me to be release to the Health Care Financing Administration, and its agents; as well as any information needed to determine benefits for related services.

Patient Payment Agreement

The CPAP/Bi-Level/Auto unit and products received are the property of GRMH. These items are considered rented until the final payments received at which time it will be considered a purchased item. GRMH reserves the right to reclaim its durable medical equipment (DME) in the event that you fail to make the payments according to the conditions outlined in this agreement.

I, __________ (initial) agree to pay the coinsurance and deductible (if applicable) for any DME received from GRMH. If equipment is rented, the rental period is cumulative and will be credited toward the final purchase price. If during your rental period your insurance should terminate, cancel, change or you no longer need this equipment, you will notify GRMH immediately. After the insurance has paid on the products the remaining balance will be forwarded to you. Payment arrangements can be made at that time.

Acknowledgment of Receipt of Privacy Notice

I, __________ (initial) acknowledge that I have received the attached Privacy Notice

Client Bill of Rights and Responsibilities

I, __________ (initial) acknowledge that I have received the attached Client Bill of Rights and Responsibilities. By signing this form, I am stating that I have received a list of my rights as a client of GRMH. I have been given an opportunity to ask questions and my questions have been answered.

Client Signature or Authorized Representative* ________________________________ Date ________________

Witness/Technician Signature ____ Date ________________

*If personal representative signature appears above, please describe personal representative's relationship to client below:

____

Graymark Healthcare is committed to partnering with patients and physicians to promote and provide excellence in sleep medicine.

For information on sleep apnea or sleep testing clinics, visit: **www.graymarkhealthcare.com**

Sleep better, live longer.℠

Info@GRMH.com | GraymarkHealthcare.com

Patient Replacement Supply Program (PRSP)

Patient name: ____ Date of Birth: ______________

Set-up Date: ____________________

Patient Replacement Supply Program (PRSP)

I, _______ (initial) would like Graymark Healthcare (GRMH) to mail replacement supplies to my residence at the available frequency approved by insurance. I realize the replacement supplies I receive will be subject to the mask and machine model and manufacturer that are currently on file. The frequency and schedule for replacement supplies will be every 3 months for all supplies except the mask interface and chamber. The mask interface and chamber will be shipped on a 6 month basis. If I would like to cancel this service I understand it is my responsibility to notify GRMH of these changes. You will begin to receive your supplies 6 months from today's date; shipping will occur on a quarterly basis. I understand that the supplies I receive will be subject to the Deductible and Coinsurance requirements and reimbursement of my insurance plan. I am aware many insurance plans require varying waiting periods before patients are eligible for replacement supplies.

Pressure Setting:

CPAP/Bi-Level pressure of: I _______ E _______ cmH2O. Ramp: _______ minutes

Please notify your Doctor if any of the following apply:

- Use CPAP/Bi-Level with untreated/undiagnosed lung condition: COPD, Emphysema, TB
- Use CPAP/Bi-Level with severe nasal congestion
- Use of CPAP/Bi-Level while receiving treatment for any other disease
- Excessive daytime sleepiness despite use of CPAP/Bi-Level treatment
- Excessive dryness despite use of heated humidification
- No reduction of symptoms within 30 days of using CPAP/Bi-Level device

Please notify Graymark Healthcare if any of the following problems occur:

- Device pressure problems (pressure feels too strong(or too much), or as if it's not getting enough pressure)
- Pressure sores from mask, due to improper fit or maladjustments
- Worn or defective equipment
- Additional education issues
- Drastic weight loss or gain
- Reorder of supplies
- Cleaning issues or questions regarding cleaning of equipment

Common Symptoms of CPAP/BiLevel use: (Symptoms can last up to 3 weeks)

- Pressure/Popping of the ears
- Nasal congestion
- Facial irritation
- Bloating or feeling of air in stomach

Client Signature or Authorized Representative* ______________________________ Date ______________

Witness/Technician Signature ______________________________ Date ______________

Graymark Healthcare is committed to partnering with patients and physicians to promote and provide excellence in sleep medicine.

For information on sleep apnea or sleep testing clinics, visit: **www.graymarkhealthcare.com**

Sleep better, live longer.℠

Info@GRMH.com | GraymarkHealthcare.com

Sleep DME Equipment Cleaning Instructions

Follow Manufacturers Guidelines

Mask Interface

- Replace every 3 to 6 months
- Cleaning: Wipe down every 2 - 3 days with a baby wipe and once a week wash with warm soapy water. Do not submerge foam (if applicable) in water. Place on a paper towel to air dry.
- Avoid using alcohol or Clorox wipes to clean mask cushion.

Headgear

- Replace every 6 months
- Cleaning: Wash once a month using a mild soap similar to baby shampoo. Hand washing is preferred.
- Most headgear will fray and become ineffective at securing the mask on your face over time. Check it regularly for elasticity and wear.

Heated Humidifier Chamber

- Replace every 6 months
- Cleaning:
  - Rinse daily with distilled water, leave upside down to air dry on a paper towel.
  - Once a week, disinfect chamber using 1 teaspoon white vinegar and distilled water; rinse thoroughly with distilled water, then place upside down on a paper towel to air dry.
  - Over time, as your humidifier chamber heats and cools, the plastic will become less pliable and brittle. The color also changes from clear to a translucent white. If not cleaned properly calcium deposits will form on the inside of the chamber. If seen, chamber should be replaced.

CPAP Hoses

- Replace every 3 months
- Cleaning: Once a week, fill your sink with warm water, add 1 Ð tablespoon of white vinegar, soak for 15 to 20 minutes, and then rinse well with warm water. Leave to air dry.
- Most hoses are very durable; however, they can get worn, damaged by pets, pinched and crushed. Check the hose regularly to make sure there are no breaks, as leaks will reduce the benefit you receive from CPAP. Hanging hose to dry will speed the drying process.

Device Filters

- Replace every 3 months
- Check your filters regularly (2-3 times a month); Make sure there are not any black specks present in the filter. If present filter needs to be replaced.
- Do not wash filters with water.
- Some filters (non disposable) are to be washed weekly

Chin Strap (if applicable)

- Replace every 6 months
- Cleaning: Wash once per month using mild dish soap. Rinse thoroughly and leave to air dry on a paper towel.
- As your chin strap wears it will become frayed and lose its elasticity letting your mouth come open during sleep, thus reducing the benefit of CPAP.

CPAP/Bi-Level Device

- Replace every 3 to 5 years; Machine has a 2 year warranty when purchased New
- Cleaning: Unplug machine. Remove filter from CPAP device; Wipe entire body of CPAP device with damp cloth and let your CPAP device air dry.
- Monthly care and cleaning of your device, regardless of manufacturer, should give you years of dependable service.
- Most devices have a 2 year warranty that covers manufacturing defects and blower motor malfunctions.
- If your device is in need of repair contact your DME representative. We will be happy to facilitate your device repair or replacement.

*Note: Always check with your insurance company for supply reorder coverage yearly.

Graymark Healthcare is committed to partnering with patients and physicians to promote and provide excellence in sleep medicine.

For information on sleep apnea or sleep testing clinics, visit: **www.graymarkhealthcare.com**

Sleep better, live longer.℠

Info@GRMH.com | GraymarkHealthcare.com

Understanding Sleep Disorder Terminology

Obstructive Sleep Apnea – Obstructive sleep apnea is characterized by repetitive pause in breathing during sleep due to the obstruction and/or collapse of the upper airway (throat), usually accompanied by a reduction in the blood oxygen saturation, and followed by an awakening to breathe.

Apnea – Apnea is defined as the cessation of breathing for 10 seconds or longer.

Hypopnea – Literally, under breathing. Breathing that is shallower than normal, resulting in reduced oxygen intake. Hypopnea is distinct from apnea; in which an apnea, there in no breathing. However, hypopneas have the same consequences for the body as apneas do.

Central Sleep Apnea - Central sleep apnea is defined as a neurological condition causing cessation of all respiratory effort during sleep, usually with decreases in blood oxygen saturation.

Apnea Hypopnea Index – (AHI) The combined number of apneas and hypopneas per hour of sleep.

Oxygen Saturation – Is a relative measure of the amount of oxygen that is dissolved or carried by the hemoglobin in the blood.

Periodic Limb Movement/Restless Leg Syndrome – (PLM/RLS) Periodic limb movement disorder (PLMD) and restless leg syndrome (RLS) are distinct disorders, but often occur simultaneously. Periodic limb movement disorders affects people only during sleep. The condition is characterized by behavior ranging from shallow, continual movement of the ankle or the toes, to wild and strenuous kicking and flailing of the legs and arms. While people with RLS complain of an irresistible urge to move their legs while at rest. The symptoms of RLS may be present all day long, making it difficult for an individual to sit motionless, which tends to compound the effects of RLS.

CPAP – (Continuous Positive Airway Pressure) is the treatment of choice for most people with obstructive sleep apnea. It involves using a small air blower device connected via a hose to mask you wear while you sleep. Essentially, this device blows air to keep your airway from collapsing and prevents an obstruction.

BiPAP – (Bi-level Positive Airway Pressure) machines deliver air flow to the airway at a certain pressure in the same manner as a CPAP, but they have different pressure for the patient's inhalation and exhalation. Inhalation pressures are higher and keep the patient's airway open, but exhalation pressure lower to make breathing out against the airflow easier for the patients. Bi-Levels are only needed in specialized cases where the pressure must be very high, or the patients cannot tolerate a standard CPAP.

Graymark Healthcare will provide state of the art durable medical equipment in a cost effective manner. We will offer the best service, education, and care in the industry, leading to a better quality of life for our patients.

Graymark Healthcare is committed to partnering with patients and physicians to promote and provide excellence in sleep medicine.

For information on sleep apnea or sleep testing clinics, visit: **www.graymarkhealthcare.com**

Sleep better, live longer.℠

Info@GRMH.com | GraymarkHealthcare.com

Medicare DMEPOS Supplier Standards

Note: This is an abbreviated version of the supplier s 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 CMS 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 procurements or non-procurements 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 then 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 action 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). *Implementation date – May 4, 2009*

For information on sleep apnea or sleep testing clinics, visit: **www.graymarkhealthcare.com**

Sleep better, live longer.℠

Info@GRMH.com | GraymarkHealthcare.com