Tidewater Lactation Group, Inc

www.tidewaterlactationgroup.com 757-422-5502

PUMP SERIAL NUMBER _____

TRICARE BREASTPUMP RENTAL CONTRACT

Terms of Breastpump Rental Agreement

This agreement for the rental of this Hospital Grade Breast pump and carrying case is made between the Rental Station above and the Lessee identified below.

1) This breastpump remains the property of Ardo or Medela. Lessee has no rights to such breastpump except as expressed in this Agreement.
2) Lessee may purchase the accessory collection kit to use with the breastpump. The kit becomes the property of the Lessee and is nonrefundable.
3) Lessee agrees to immediately pay any rental fees not covered by TRICARE. If Lessee wishes to continue renting the breastpump longer than covered by TRICARE, they must call the Rental Station office above and make arrangements for payment to extend the rental.
4) Lessee agrees not to move the breastpump out of this State without the written and signed consent of the Rental Station.
5) Lessee agrees to inform the Rental Station of any change of address or phone number, duty station and duty phone number.
6) Lessee agrees to return the breastpump in good repair. If not in good repair, Lessee agrees to pay for all repairs.
7) Lessee shall be responsible for all reasonable legal fees and other costs involved in collection of overdue amounts and recovery of breastpump.
8) Lessee understands the Rental Station has the right to Recall the breastpump at any time and for any reason with three days notice.
9) Lessee agrees that their credit card can be charged for the cost of a new hospital grade breastpump equal to that which was rented if the breastpump is not returned to the Rental Station. (Hospital Grade Breastpumps range in price from $950.00 to $2300.00.)
10) Lessee agrees any unpaid balance will be charged to their credit card immediately, if not paid in another form.
11) Lessee agrees to bring the breastpump back to the Rental Station once the breastpump is no longer being used.
12) This Agreement shall be construed under the laws of the State where the Rental Station is located.
13) Lessee agrees to allow any agency involved in collection of overdue amounts and /or the rental breastpump to obtain a credit report on Lessee.
14) Lessee agrees that the LESSEE named in this contract will be the only user of this breastpump.

PLEASE PRINT

LESSEE NAME: _____ **DATE OF BIRTH** _____

CELL PHONE: _____ **WORK PHONE:** _____ **SECONDARY/SPOUSE PHONE:** _____

ADDRESS: _____ **CITY, STATE, ZIP:** _____

SPONSOR NAME/Relationship to Lessee _____ **EMAIL ADDRESS:** _____

DUTY STATION: _____ **DUTY PHONE:** _____ **CO/Chief:** _____

DRIVER'S LICENSE NO. _____ **STATE** _____ **SPONSOR SSN** _____

CREDIT CARD # ____ ____ ____ ____ -____ ____ ____ ____ - ____ ____ ____ ____ -____ ____ ____ ____ **EXP. DATE** ____ ____/____ ____

TYPE OF CREDIT CARD **VISA** **MASTERCARD** **CARD VERIFICATION #** ____ ____ ____ **(3 digits on back)**

RELATIVE NAME (*does not live in same household*): _____ **RELATIONSHIP:** _____

ADDRESS: _____ **CITY, STATE, ZIP:** _____ **PHONE:** _____

_____ Initial here Any cost share/deductibles due are charged automatically each month to the card on file.

_____ Initial here When the breastpump is no longer covered by Tricare, the pump will be **automatically renewed** by the rental station until the Lessee contacts the rental station with a pump return date.

_____ Initial here My Monthly rental amount will be $ _____ if the pump is not returned by _____

*I hereby agree to the terms and conditions of this rental agreement. I also authorize **Rental Station** to **charge my credit card on file** according to the terms of this rental agreement.*

SIGNATURE of LESSEE: _____ **DATE** _____

PRIVACY NOTICE: The information collected in this contract is considered nonpublic personal information and will only be used in accordance with this contract. We maintain physical, electronic, and procedural safeguards that comply with federal and state regulations regarding your privacy and to guard all nonpublic information.

For Office Use

_____ Loaned Cup Holders _____ (Lessee Initial)
_____ Loaned Y Connectors _____ (Lessee Initial)
_____ Yellow Caps $8.80 _____ (Lessee Initial)
_____ Caps and Tubing $30.00 _____ (Lessee Initial)

Pump Returned on: _____

Rental Station Initial Here: _____

NOTES _____

Just a few reminders about your breast pump rental from Tidewater Lactation Group, Inc.

1. Our Symphony Pump is the same as the one you may have used in the hospital except that it needs to be plugged into the back. There is a flap on the back of the breast pump with a smiley face on it. Lift it and plug in the short part of the power cord. The long end plugs into the wall outlet. DO NOT remove or manipulate the back plate where the power cord is attached to the pump. Doing so will affect the performance of the pump.
2. Our Carum Pump is similar to the Ameda you may have used in the hospital except that it needs 2 "Y" connectors, which we have provided to you.

3. The pump's return date is highlighted on your contract. There is also a reminder card with the return date attached to the top of the pump.
    a. Tricare will typically cover the breast pump for three months or as long as the baby is in the NICU.
    b. If the baby is still in the NICU by the return date and you want to continue to use the breast pump, please contact us BEFORE that date to let us know. Hospitals do not let us know when babies are in or out of the NICU.
    c. If you want to extend your rental past that date and the baby is out of the NICU please call our office BEFORE the due date and we will direct you on how to move forward.
    d. If you stop using the breast pump prior to the date listed please return it to our office because it is ALWAYS in high demand for our NICU babies.

4. Everything inside of the case including the case and power cord will be returned back to the office.
5. PLEASE CALL THE OFFICE TO UPDATE ANY CHANGES TO YOUR CONTACT INFORMATION such as credit card number, Tricare enrollment status, phone numbers, address etc.

By signing below you have read and understand all of the information listed above.

Name (Print): _____

Signature: _____Date: _____/_____/_____

TRICARE Other Health Insurance (OHI) questionnaire

Do you or any of your family members have Other Health Insurance (OHI) coverage or have you had OHI in the last 12 months? (TRICARE supplements are not OHI) ☐ Yes ☐ No

If **Yes**, complete the questionnaire for each insurance policy and fax/mail to the address provided on page one. **Important:** If there was a break in OHI coverage, please include information about the previous OHI coverage. **Coverage type:**

☐ HMO/PPO ☐ Medicare ☐ Single ☐ Group ☐ Supplemental ☐ Private ☐ Medicaid/MediCal ☐ Student health plan

☐ Other: _____ Policy #: _____

Policyholder name: _____

Group/Plan #: _____ SSN/DBN #: _____

Sponsor ID #: _____ Name of carrier: _____

Carrier address: _____

Carrier phone #: _____ Effective date: _____ Expiration date: _____

This policy provides the following benefits (check all that apply):

☐ Pharmacy ☐ Dental ☐ Vision ☐ Behavioral health ☐ Durable Medical Equipment (DME)

List who is covered by this policy (if additional people are covered, please attach a separate list):

Name of covered member: _____

Relationship to policyholder: _____ Gender: _____

DOB (dd/mm/yyyy): _____ SSN/DBN: _____ Effective date: _____

Name of covered member: _____

Relationship to policyholder: _____ Gender: _____

DOB (dd/mm/yyyy): _____ SSN/DBN: _____ Effective date: _____

The statements made above are true and correct to the best of my knowledge. I understand that Federal Laws *18 U.S.C. 287* and *1001* provide for criminal penalties for submitting or making false, fictitious or fraudulent statements or claims in any matter within jurisdiction of any department or agency of the United States. I further understand that copies of the laws cited may be obtained from uniformed services legal offices, public libraries and many beneficiary counseling and assistance coordinators.

Signature: _____ Sponsor SSN: _____

Name (printed): _____ DOB: _____ Date: _____

Relationship to sponsor: _____

Humana Military | TRICARE®

TRICARE Other Health Insurance (OHI) questionnaire

Privacy Act Statement

This statement serves to inform you of the purpose for collecting personal information required by Humana Military Automated Information System and how your personal information will be used.

Authority: *10 U.S.C. Chapter 55, Medical and Dental Care; 10 U.S.C. 1079 Contracts for Medical Care for Spouses and Children: Plans and 1086 Contracts for Health Benefits for Certain Members, Former Members, and Their Dependents; 38 U.S.C. Chapter 17 Hospital, Nursing Home, Domiciliary, and Medical Care; 32 CFR Part 199, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS);* and *E.O. 9397 (SSN)*, as amended.

Purpose: To obtain information from individuals to validate their eligibility as beneficiaries, grant access to the Humana Military website, and provide beneficiary services available through Humana Military to validated individuals, including physician referrals, healthcare authorizations, claims payment, assignment of beneficiaries to physicians, and informational contact with validated beneficiaries.

Routine uses: Information collected may be used and disclosed generally as permitted under *45 CFR Parts 160* and *164*, Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules, as implemented by *DoD 6025.18-R, the DoD Health Information Privacy Regulation*. Information may also be used and disclosed in accordance with *5 U.S.C. 552a(b) of the Privacy Act of 1974*, as amended, which incorporates the DoD Blanket Routine Uses published at: ***dpcld.defense.gov/Privacy/SORNsIndex/Blanket-Routine-Uses***. Information collected from you may also be shared with the Departments of Health and Human Services and Homeland Security, and other Federal, State, local, and foreign government agencies, private business entities under contract with the Department of Defense, and individual providers of care, on matters relating to eligibility, claims pricing and payment, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil or criminal litigation.

Disclosure: Voluntary; however, failure to furnish all requested information will result in an individual not being able to access beneficiary services available through Humana Military.

Reporting your OHI

You can report and update your OHI to minimize any delay in processing claims through the following methods:

Phone: (800) 444-5445

In person: Visit your uniformed services identification card-issuing facility

Mail: TRICARE East Region
P.O. Box 8923
Madison, WI 53708-8923

Fax: (608) 221-7536

Visit **HumanaMilitary.com** and ***TRICARE.mil/OHI*** for more information on OHI.

If you have received this correspondence in error, please notify (800) 444-5445, then destroy completed documents and any copies you have made.

Humana Military | TRICARE®

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) ☐ YES ☐ NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd. for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

Clear Form

Tidewater Lactation Group, Inc.
CONSENT FORM

Consent Agreement to be READ, INITIALED & SIGNED before the Lactation Visit

_____ I understand the lactation consultant is an allied health care provider and is responsible for evaluating and recommending a care plan to resolve or improve breastfeeding issues. A lactation visit includes a detailed history of mother/infant, an assessment of maternal/infant anatomy, observation of a feeding for evaluation of technique and effectiveness of feeding, and recommendations for management to improve and/or resolve breastfeeding related issues. All clients are provided with a written and/or verbal care plan to improve breastfeeding concerns. The client and the lactation consultant each have responsibilities in this plan. Resolution of a breastfeeding problem often takes several days or weeks and may require a change in the original recommended care plan at some point.

_____ I understand that I am responsible for informing the lactation consultant of changes I feel are necessary in the care plan at the time of the visit or during the course of follow-up communication. Phone contact after the lactation visit is important and considered an extension of the visit. I understand it is my responsibility to call the lactation consultant with progress reports, questions or concerns.

_____ I understand any instructions or recommendations given may be discussed with one or both of our health care providers.

_____ I understand a partial or follow-up visit is sometimes necessary. I understand that breastfeeding supplies and/or breast pumps may be recommended as effective management of specific situations. Only effective equipment will be recommended.

_____ I hereby authorize the lactation consultant to release any information acquired in the evaluation and/or management of myself and/or my child to our health care providers, referring physician, and/or our insurance company upon request. I understand the lactation consultant may contact my physician or my child's physician if necessary.

_____ I have received a copy of this provider's Privacy Practices. (HIPAA Compliance)

_____ I understand this practice accepts **fee for service at time of service** if they do not bill my insurance**.** It is my responsibility to pursue reimbursement for lactation services from my insurance company. (Reimbursement from your insurance company is not guaranteed, but will depend on your policy. Filing a claim is suggested even if you feel it will not be a covered benefit in your policy.)

OR

_____ I understand that this practice participates with some insurance companies and will file the claim for me. If the claim is denied, the payment and any co-pay will be my responsibility.

_____ I give permission for photos and/or videos of my lactation visit to be used for professional education.

Signature_____ **Date**_____

Who may we thank for your referral? _____

Tidewater Lactation Group

NOTICE OF PRIVACY PRACTICES
EFFECTIVE DATE: APRIL 14, 2003

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.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION

Each time you visit a hospital, physician, dentist, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a basis for planning your care and treatment and serves as a means of communication among the many health professionals who contribute to your care. Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and helps you make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS

Unless otherwise required by law, your health record is the physical property of the healthcare practitioner or facility that compiled it. However, you have certain rights with respect to the information. You have the right to:

1. **Receive a copy of this Notice of Privacy Practices** from us upon enrollment or upon request.
2. **Request restrictions on our uses and disclosures of your protected health information** for treatment, payment and health care operations. However, we reserve the right not to agree to the requested restriction.
3. **Request to receive communications of protected health information in confidence.**
4. **Inspect and obtain a copy of the protected health information** contained in your medical and billing records and in any other Practice records used by us to make decisions about you. A reasonable copying charge may apply.
5. **Request an amendment to your protected health information**. However, we may deny your request for an amendment, if we determine that the protected health information or record that is the subject of the request:
   - was not created by us, unless you provide a reasonable basis to believe that the originator of the protected health information is no longer available to act on the requested amendment;
   - is not part of your medical or billing records;
   - is not available for inspection as set forth above; or
   - is accurate and complete.

   In any event, any agreed upon amendment will be included as an addition to, and not a replacement of, already existing records.
6. **Receive an accounting of disclosures of protected health information** made by us to individuals or entities other than to you, except for disclosures:
   - to carry out treatment, payment and health care operations as provided above;
   - to persons involved in your care or for other notification purposes as provided by law;
   - to correctional institutions or law enforcement officials as provided by law;
   - for national security or intelligence purposes;
   - that occurred prior to the date of compliance with privacy standards (April 14, 2003);
   - incidental to other permissible uses or disclosures;
   - that are part of a limited data set (does not contain protected health information that directly identifies individuals);
   - made to patient or their personal representatives;
   - for which a written authorization form from the patient has been received
7. **Revoke your authorization to use or disclose health information** except to the extent that we have already taken action in reliance on your authorization, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer that obtained the authorization with the right to contest a claim under the policy.

OUR RESPONSIBILITIES

We are required to maintain the privacy of your health information. In addition, we are required to provide you with a notice of our legal duties and privacy practices with respect to information we collect and maintain about you. We must abide by the terms of this notice. We reserve the right to change our practices and to make the new provisions effective for all the protected health information we maintain. If our information practices change, a revised notice will be mailed to the address you have supplied upon request. If we maintain a Web site that provides information about our patient/customer services or benefits, the new notice will be posted on that Web site. Your health information will not be used or disclosed without your written authorization, except as described in this notice. Except as noted above, you may revoke your authorization in writing at any time.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions about this notice or would like additional information, you may contact our Privacy Officer at the telephone or address below. If you believe that your privacy rights have been violated, you have the right to file a complaint with the practice's Privacy Officer or with the Secretary of the Department of Health and Human Services. We will take no retaliatory action against you if you make such complaints.

The contact information for both is included below.

U.S. Department of Health and Human Services Office of the Secretary 200 Independence Avenue, S.W. Washington, D.C. 20201 Tel: (202) 619-0257 Toll Free: 1-877-696-6775	Tidewater Lactation Group, Inc Elizabeth Flight, Privacy Officer 5741 Cleveland St. Suite 150 Virginia Beach, VA 23462 Tel: (757) 422-5502