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 OHI Questionnaire

Do you or any of your family members have OHI coverage? **Yes** ☐ **No** ☐
Have you had OHI within the last 12 months? (TRICARE supplements are not OHI) **Yes** ☐ **No** ☐

If **Yes**, complete the questionnaire for the new 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.

Is this a change in OHI Coverage? **Yes** ☐ **No** ☐ If **Yes**, what is the 'previous' OHI: _____

Effective Date:_____ Expiration Date:_____

TRICARE Sponsor Name: _____ TRICARE Sponsor SSN: _____

OHI Coverage type: Check all that apply:

☐ HMO/PPO ☐ Medicare ☐ Medicaid/MediCal ☐Student Health Plan ☐ Dental ☐ Vision

Policyholder Name: _____ SSN/DBN #: : _____ DOB: _____

Name of Carrier: _____ Policy #: _____ Group #: _____

Effective Date: _____ Expiration Date: _____ Carrier Phone:_____

Carrier Address: _____

Is TRICARE beneficiary covered under this policy: Yes ☐No ☐

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

Name: _____ DOB (dd/mm/yyyy): _____ Gender:_____
Relationship to Policyholder: _____ Effective Date: _____ Expiration Date: _____

Name: _____ DOB (dd/mm/yyyy): _____ Gender:_____
Relationship to Policyholder: _____ Effective Date: _____ Expiration Date: _____

Name: _____ DOB (dd/mm/yyyy): _____ Gender:_____
Relationship to Policyholder: _____ Effective Date: _____ Expiration Date: _____

Review OHI at beneficiary self-service: https://infocenter.humana-military.com/beneficiary/service/Account/Login

FAQ can be found here: https://tricare.mil/About/Regions/East-Region/Claims/OHI

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: _____ Name (Printed): _____

Date Signed: _____ Relationship to TRICARE Sponsor: _____

TRICARE® EAST REGION

HEALTH INSURANCE CLAIM FORM

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

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

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 _____

PHYSICIAN OR SUPPLIER 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	

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.

Tidewater Lactation Group, Inc

Consent Agreement to be READ & 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 a care plan in their Parent Portal 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. A partial or follow-up visit is sometimes necessary.

- This practice uses a HIPAA compliant Electronic Health Record system, MilkNotes©, referred to throughout this consent form as my "Parent Portal". My unique log-in gives me full access to information stored there.

- 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. Secure Messaging through my Parent Portal after the lactation visit is important and considered an extension of the visit. I understand it is my responsibility to contact the lactation consultant with progress reports, questions, or concerns.

- 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. I understand the lactation consultant may contact my physician or my child's physician if necessary to discuss any instructions or recommendations given.

- I understand that any photos and/or videos taken with my knowledge during my lactation visit will be uploaded to my Parent Portal and relevant to my care. **Pictures are not for social media.**

- I have read this provider's Privacy Practices (HIPAA Compliance), available in my Parent Portal.

- I have read this provider's Cancellation Policy and understand that by providing my Credit Card information I am agreeing to the terms of this policy.

- I understand that this practice uses Artificial Intelligence recording via MilkNotes software. This feature is currently in its "testing phase".

- 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 and charged to my card on file.
- This practice accepts a 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.)

Signature_____ Date_____