APRIA®

APRIA Great Escapes™

Portable Oxygen Concentrator Rental Agreement for Travel

(Blank spaces should be completed by hand)

This Agreement relates to the rental by Apria Healthcare LLC ("Company") of a portable oxygen concentrator and related equipment as well as the sale of certain related supplies to the undersigned patient or authorized patient representative.

Equipment Rented and Sold/Agreement Overrides Printed Sales Service and Rental Agreement Terms

The equipment being sold and rented and the charges therefore are identified on the following Apria Healthcare Sales Service and Rental Agreement ("SSRA") No. _____. The Terms and Conditions/Authorizations/Consents contained in this Agreement will supersede and override any contrary provisions set forth in the SSRA, but shall not override the arbitration provisions therein contained or any other provisions not expressly amended hereby.

Return Date_____, 20___
Branch Return Location_____

Terms and Conditions/Authorizations/Consents

Signer and Patient Responsible for Payment. The undersigned is the patient or the patient's authorized representative and agrees to the terms and conditions contained on the front and back of this form and the other documentation provided by Apria, including but not limited to the following: (a) I acknowledge that the Responsible Party (as defined below) is primarily responsible to pay the charges for the equipment and services listed in this Agreement; (b) any rental covered by this Agreement belongs to Apria, and the Responsible Party may be charged for any loss or damage to it; (c) I have received and fully inspected the equipment listed on the SSRA and it is complete and in good working order without defects; (d) I have been instructed on the proper care, use, service, safe operation and maintenance of the equipment listed in this Agreement as appropriate. The credit card to be charged is as follows:

Credit Card: ☐ Visa ☐ MasterCard ☐ Discover Card No. _____

Exp. Date: _____ Auth. Amt. _____ Auth. Code _____

By signing below I acknowledge that I have been given an opportunity to read both pages of this Agreement before being asked to sign it. My signature authorizes Apria Healthcare to process one or more credits as listed above and as otherwise described in this Agreement and my agreement to and acceptance of all of the terms and conditions of this Agreement.

Responsibility for Equipment. BY SIGNING BELOW I ACKNOWLEDGE THAT I AM RESPONSIBLE FOR ALL DAMAGE TO THE EQUIPMENT, EVEN IF CAUSED BY SOMEONE ELSE OR IF THE CAUSE IS UNKNOWN. I AM RESPONSIBLE FOR AND MY CREDIT CARD MAY BE CHARGED FOR THE FULL COST OF REPAIR OR REPLACEMENT UP TO THE RETAIL REPLACEMENT VALUE OF THE EQUIPMENT IN THE EVENT IT IS RETURNED IN A DAMAGED CONDITION OR IF I FAIL TO RETURN IT BY THE REQUIRED RETURN DATE.

Geographical Restrictions. USE OF THIS EQUIPMENT IS RESTRICTED TO THE UNITED STATES. APRIA HEALTHCARE IS UNABLE TO SUPPORT OPERATION OF THE EQUIPMENT OUTSIDE OF THE UNITED STATES OR AREAS WITHIN THE UNITED STATES NOT SERVICED BY APRIA HEALTHCARE. I understand that I must consult with my Apria Healthcare Branch concerning my itinerary before making final trip arrangements.

Airline Travel with Portable Oxygen Concentrators. Some airlines may not accept portable oxygen concentrators and/or only accept specific types; these requirements change from time to time without notice to the Company. Contact your airline for their rules on traveling with medical devices. The Company does not have permanent arrangements with any airline regarding the equipment I am receiving under this Agreement, and the Company does not take responsibility for assuring that I will be able to travel on any particular airline with this equipment.

Other Equipment May Be Needed. The portable oxygen concentrators are not approved for overnight usage in every case. I understand that I must check with the Company branch from which I receive the equipment and my physician in order to determine what additional equipment I will need when I arrive at my destination. The Company may be able to assist me in arranging for additional equipment.

Agreed to and Accepted (Signature): _____ **Date:** _____

Print Name: _____ **Telephone Number:** _____

Consent/Authorization. I hereby authorize and consent to the provision of products and/or services ("Equipment") by the company designated in this Agreement or on the SSRA to me or the patient for whom I am legally responsible and for whom I am signing this form (the "patient"). I also understand that the patient's medical treatment is under the control of the patient's physician and that the Company is not liable for any act or omission when following the instructions of the patient's physician. I hereby authorize anyone who has medical, insurance or claims information about the patient to release to the Company any records or information about the patient's treatment, medical condition and history, insurance information and claims status, and about all medical equipment and services provided to the patient. I also authorize the release of the patient's records and any other information about the patient by the Company to (a) any entities responsible for payment of the patient's healthcare costs ("Third Party Payors") for use in determining the patient's benefits or eligibility; (b) The Joint Commission, and other licensing, oversight, accreditation and regulatory entities; and (c) the Company's affiliates or others assisting in the care, billing, collection or verification processes. I have the right to refuse the release of the patient's personal and medical records now held by the Company and am waiving that right by signing this form. This consent will be valid for the time period necessary for the entity requesting the patient's records to fulfill its purpose, or until I revoke this consent in writing. Any revocation of this consent will only be effective as to Equipment provided after the date the revocation is received by the Company.

Patient/Responsible Party Financial Responsibility. To the extent allowed or required by law and unless otherwise agreed in writing by the Company, the patient and/or the patient's parent(s), guardian(s), personal representative(s), heir(s), spouse and/or any other person who is legally responsible for the patient ("Responsible Party"), are primarily responsible for assuring that the Company is paid for the Equipment. The Company reserves the right to make appropriate corrections to any errors on the front of this form or on the SSRA. Even if partial payment may be made by Third Party Payors, the Responsible Party remains obligated for copayments, deductibles and any other amounts not paid or covered by Third Party Payors to the maximum extent allowed by law ("Patient Responsibility Amount"). The Responsible Party will pay the full amount due to the Company. The Responsible Party will notify the Company promptly in writing of any change of its residence or mailing address.

Billing and Payment of Accounts. The Responsible Party is required to pay any Patient Responsibility Amount as it becomes due, and payment for bills issued to a Responsible Party for a Patient Responsibility Amount is due upon receipt of the bill. Any payment by the Responsible Party or acceptance by the Company of a lesser amount than is due shall be treated as a payment on account. Any endorsement or statement on the check or accompanying letter that such lesser amount is payment in full shall have no effect, and the Company may accept such payment without prejudice to any other rights or remedies it may have. If the Responsible Party fails to pay any amount owed, the Company may pursue all remedies available at law or in equity, including, but not limited to, the return of the Equipment to the Company and the commencement of legal proceedings. The Responsible Party will be responsible for all attorneys' fees and costs incurred by the Company.

Patient Responsibility. The Responsible Party's responsibility for certain Patient Responsibility Amounts may be limited by legal or contractual requirements. In those cases, the Company will not intentionally bill the Responsible Party for the portion of the Patient Responsibility Amount that is subject to the limitation and will make appropriate corrections to the patient's account for any bills that may have been sent in error. The Responsible Party should notify the Company at the phone number indicated on the front of this form of any billing errors the Responsible Party believes may have been made, so appropriate corrections can be made.

The Company Is and Shall Remain the Owner of All Rental Equipment. All Rental Equipment is being provided on a rental basis, with rental payments due periodically. Except as specifically provided to the contrary under applicable rent-to-purchase provisions in a contract between the Company and the patient's Third Party Payor or in applicable laws or regulations of government programs such as Medicare or Medicaid, the Rental Equipment shall at all times be the sole and exclusive property of the Company or its affiliate, and the Responsible Party shall have no rights or property interest in the Rental Equipment, other than the right of the patient to use it in a reasonable manner consistent with its intended purpose and in accordance with instructions received from the Company and/or the patient's physician. The Responsible Party agrees not to remove or alter any identification on any Rental Equipment or in any way attempt to transfer any Rental Equipment. Rental Equipment will be returned to the Company in the same condition as it was delivered, reasonable wear and tear expected.

Late Returns. I am responsible for the Rental Equipment until such time as it is actually received at the Company's branch location listed on the front of this document. My obligation to return the same is not diminished by the fact that I may deliver the Rental Equipment to UPS or another third party shipping service paid for by the Company. If the equipment is returned after the Return Date listed on the front of this document, I understand that I will be billed and that my credit card may be charged for one day of rental at the Late Return Rate, for each day passing from the Return Date listed until the date it is returned. If it is not returned within 10 days after the Return Date listed on the front of this document, I may be billed and my credit card charged for the entire replacement cost of the Rental Equipment and upon receipt of payment of such amount by Apria, I will thereafter become the owner of the Rental Equipment so paid for.

Care of Equipment. The Responsible Party must take reasonable care of the Rental Equipment, may not abuse the Rental Equipment and must promptly notify the Company of any problems with the Rental Equipment while it is in the patient's possession. The Responsible Party must promptly notify the Company and return the Rental Equipment in good condition if the patient stops using it or no longer needs it. The Responsible Party will remain responsible for and continue to be billed for the Rental Equipment until it is returned to the Company in good condition. The Company will perform routine maintenance for all Rental Equipment and make any repairs that are necessary due to ordinary use. Instead of or while making repairs, the Company may provide appropriate substitute equipment.

Liability for Damage and Return. The Responsible Party shall be responsible for (i) any damage to the Rental Equipment beyond ordinary and reasonable wear and tear; (ii) the loss of the Rental Equipment while it is in the Responsible Party's possession, and (iii) payment to the Company for any such damaged or lost Rental Equipment.

Warranty/Limits of Liability. If difficulties arise with the Equipment, contact the Company at the number provided below, and the Company will attempt to provide non-emergency assistance. In the case of an emergency, call 911. Equipment which is manufactured by someone other than the Company may include a warranty by the manufacturer. If there is a manufacturer's warranty in effect, the Company will make a copy available to the Responsible Party upon request. Only the manufacturer is responsible for performance under its warranty. THE COMPANY MAKES NO EXPRESS WARRANTIES WHATSOEVER WITH RESPECT TO THE EQUIPMENT. MOREOVER, TO THE EXTENT PERMITTED BY THE LAW, **THE COMPANY HEREBY DISCLAIMS ALL IMPLIED WARRANTIES, INCLUDING THE IMPLIED WARRANTIES OF MERCHANTABILITY AND OF FITNESS FOR A PARTICULAR PURPOSE, THE RESPONSIBLE PARTY ACKNOWLEDGES RECEIPT OF THE EQUIPMENT "AS IS" WITHOUT ANY WARRANTIES, EXPRESS OR IMPLIED, ON THE PART OF THE COMPANY** AND AGREES TO BE BOUND BY THE LIMITATIONS IN THIS PARAGRAPH TO THE EXTENT ALLOWED BY APPLICABLE LAW. The Responsible Party agrees that the Responsible Party is solely responsible for all damage and liability arising out of use of the Equipment except that resulting from the Company's negligence or a defect in the Equipment. THE COMPANY'S LIABILITY, INCLUDING FOR THE COMPANY'S NEGLIGENCE OR FOR A DEFECT IN THE EQUIPMENT, WILL IN NO EVENT EXCEED THE SALE PRICE OR RENTAL ALLOWABLE FOR THE INDIVIDUAL PIECE OF EQUIPMENT. THE RESPONSIBLE PARTY AGREES THAT THE AVAILABLE REMEDIES ARE LIMITED TO THE REFUND OF AMOUNTS PAID, OR THE REPAIR OR REPLACEMENT OF THE EQUIPMENT. THE COMPANY WILL NOT BE LIABLE FOR ANY OTHER DIRECT, INCIDENTAL, CONSEQUENTIAL, OR EXEMPLARY DAMAGES FOR ANY REASON WHATSOEVER.

Miscellaneous. This form and other documentation provided to the Responsible Party by the Company represent the entire agreement ("Agreement") between the parties and supersede all prior oral and/or written agreements and representations. No provision of this Agreement may be waived or modified, unless in writing and signed by the Company.

Certifications. By executing the front of this form, I hereby certify that I (a) have received and been given an opportunity to read a copy of the Patient/Client Bill of Rights, Patient Responsibilities and Medicare Supplier Standards; (b) have received my home healthcare company's Notice of Privacy Practices on or before the date of delivery of the Equipment.

If you have questions concerning your equipment or the Portable Oxygen Concentrator and Travel Oxygen Program call (844) 235-2738. In case of emergency dial 911.