Patient Agreement and Consent

ACCOUNT NUMBER				
PATIENT NAME		EMAIL		
ADDRESS-STREET	CITY	STATE	ZIP	Cell phone No.
TYPE OF EQUIPMENT DME and Supplies			EFFECTIVE DATE:	

REQUEST FOR PRODUCTS, EQUIPMENT, SUPPLIES, SERVICES

The undersigned, being the above-named patient ("Patient"), his/her guardian or representative payee, understands that by signing this Patient Agreement and Consent, the undersigned desires to rent or purchase, as or on behalf of Patient, certain medical equipment, products, supplies, prescription drugs and/or associated services (collectively, to the extent applicable, the "Items") from SUPPLIER and its affiliates.

ACKNOWLEDGEMENT OF MEDICAL RESPONSIBILITY AND INFORMED CONSENT

The undersigned, as or on behalf of Patient, understands that (1) Patient is under the supervision and control of an attending physician; (2) Patient's physician has prescribed the Items noted as part of Patient's treatment; (3) SUPPLIER's services do not include diagnostic, prescriptive or other functions typically performed by physicians; and (4) Patient's physician is solely responsible for diagnosing and prescribing the Items or other therapies for Patient's condition and otherwise for controlling Patient's medical care. The undersigned, as or on behalf of Patient, has been informed by Patient's physician of the possible increased risks associated with in-home care, including possible delays in receiving treatment for life threatening conditions as a result of being outside the hospital setting. The undersigned, as or on behalf of Patient, has discussed his/her concerns with Patient's physician and has had all associated questions answered to his/her satisfaction.

ACKNOWLEDGEMENTS OF RECEIPT AND AGREEMENT TO CONTACT

The undersigned, as or on behalf of Patient, acknowledges receipt of a copy of each of the following: (1) the Medicare DMEPOS Supplier Statement;(2) SUPPLIER's Notice of Privacy Practices; (3) the Patient's Bill of Rights; and (4) the Patient Responsibilities. The undersigned, as or on behalf of Patient, agrees that SUPPLIER and its affiliates may contact Patient at the telephone number and/or email address specified hereon or as provided by the undersigned or Patient in the future.

CONSENT TO RELEASE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

The undersigned, as or on behalf of Patient, authorizes (1) Patient's insurer(s) and any other third party payor(s) which provide Patient with coverage to disclose to SUPPLIER minimum necessary information to facilitate payment to SUPPLIER for items furnished Patient including, but not limited to (A) payment made by such payor(s) to Patient, the undersigned or to any other person or entity for Items provided by SUPPLIER to Patient; and (B) the scope and extent of Patient's coverage from time to time; (2) all medical personnel involved in Patient's treatment to disclose to SUPPLIER any and all information concerning Patient's medical history and condition as it may relate to the Items or treatment provided to Patient by SUPPLIER; and (3) any holder of medical information about Patient (including SUPPLIER) to release to the Centers for Medicare & Medicaid Services (or any successor agency) and its agents, to any of Patient's third party payor(s) including, without limitation, Medicare, Medicaid, CHAMPUS, Tricare or other public or private payors, and to SUPPLIER, any information needed (subject to "minimum necessary" requirements, as applicable) (A) to determine applicable benefits and qualification for reimbursement of Items furnished by SUPPLIER to Patient; (B) to process claims for Items provided by SUPPLIER to Patient; and/or (C) to conduct health care compliance activities (including pre- and post-payment audits) and quality assurance and utilization reviews. The undersigned, as or on behalf of Patient, hereby authorizes his/her health care providers and payors to rely on this "Consent to Release of Health Information," without the need for a separate release authorization, to release the specified information for treatment, payment and health care operations purposes as contemplated herein. This consent shall not be effective to permit disclosures of information in cases where a HIPAA-compliant release authorization is required by law.

AGREEMENT TO PAY

The undersigned agrees to pay for all Items provided by SUPPLIER to Patient. The monthly balance due will be that portion of SUPPLIER's applicable charges not paid by insurance or any other payor, including coinsurance, co-payment and deductible amounts, as well as amounts due for non-covered Items provided to Patient by SUPPLIER. The undersigned agrees to pay the balance due in full upon receipt of an invoice from SUPPLIER. If prompt payment is not made, SUPPLIER may pursue its standard collection policy or other applicable remedies at SUPPLIER's sole discretion. If the undersigned fails to pay any amount due hereunder, he/she hereby grants SUPPLIER a lien and security interest under the Uniform Commercial Code in any personal property of the Patient to secure payment. If payment is more than 90 days past due, SUPPLIER may take all actions permitted by law to enforce the security interest and lien.

CREDIT CHECK AUTHORIZATION

The undersigned, as or on behalf of Patient, authorizes SUPPLIER (1) to verify any financial or payment information disclosed by Patient or the undersigned and to perform a credit investigation for the purpose of extending credit for the purchase or rental of Items and (2) to answer any questions from other creditors about Patient's or the undersigned's credit and account experience with SUPPLIER. **ASSIGNMENT OF BENEFITS**

The undersigned, as or on behalf of Patient, requests that payment of authorized benefits be made to SUPPLIER, and authorizes SUPPLIER to collect directly all public and private insurance coverage benefits due, for any Items furnished to Patient by SUPPLIER. In the event benefit payments due SUPPLIER are paid directly to Patient or the undersigned, the payee shall immediately, and without request from SUPPLIER, endorse and remit to SUPPLIER all such benefit payment checks. On assigned Medicare claims, SUPPLIER shall accept the applicable Medicare allowable amount (including deductibles and co-payment) in full for covered Items.

MISCELLANEOUS

The undersigned certifies that the information provided to SUPPLIER by or on behalf of Patient under Medicare (Title XVIII of the Social Security Act) and/or any other public or private health insurance is correct. Patient, if physically and mentally competent, must sign this Patient Agreement and Consent on his/her own behalf. If Patient cannot sign for himself/herself, the source of the undersigned's authority to sign on behalf of Patient must be stated. This Patient Agreement and Consent is used in lieu of Patient's or his/her representative's signature on the "Request for Payment" HCFA-1500 and on other health insurance claim forms requiring signature and thus, is an extension of those forms. Any person who misrepresents or falsifies information in making a claim under Medicare or any other federal health care program may, upon conviction, be subjected to fines and imprisonment under federal law. Penalties may also result from falsification or misrepresentation of other health insurance claims. A copy of this Patient Agreement and Consent may be used in place of the original.

The undersigned certifies that he/she (1) is the Patient, or is duly authorized to execute this Patient Agreement and Consent and accept its terms as or on behalf of Patient and (2) has read the foregoing and understands and agrees to the terms hereof as or on behalf of Patient.

Area Manager _____ **Telephone** _____

X_____ _____ _____

PATIENT, GUARDIAN OR AUTHORIZED REPRESENTATIVE **AUTHORITY TO SIGN** **DATE**

X_____ _____ _____

AUTHORIZED REPRESENTATIVE ADDRESS **EMAIL** **CELL PHONE**

CONSENT TO BE CONTACTED

Patient consents to receiving calls, emails, and texts from SUPPLIER and its affiliates related to the Patient's account, special offers from SUPPLIER and its affiliates, and advertising and telemarketing messages, which are made through automatic telephone dialing systems or an artificial or prerecorded voice at the telephone number and email address provided above. Standard message and data rates may apply. Signing this consent is NOT a condition of receiving services or equipment, or a condition of purchasing any property, goods, or services from SUPPLIER. The undersigned confirms that the telephone number and/or email address provided above are true and correct and belong to the Patient. I agree to notify the SUPPLIER in writing in the event my email address or telephone number changes.

Patient/Authorized Representative Signature: _____ Date:_____

HIPAA MARKETING AUTHORIZATION

SUPPLIER is hereby authorized to use and disclose my contact information and order history to make marketing communications to me about products or services that I might be interested in. This Authorization will expire 15 months following the last date SUPPLIER furnished products and/or services, or at any time you choose to revoke this Authorization by calling _____. SUPPLIER may not condition your receipt of services or equipment on whether you choose to sign this Authorization. Disclosures for this purpose will only be made to SUPPLIER's contracted printers/mailing houses, not to manufacturer partners. I acknowledge that SUPPLIER may receive financial remuneration from an affiliate or manufacturer whose product or service is being marked. By law, we are required to notify you that information disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and thus no longer protected by HIPAA.

Patient/Authorized Representative Signature: _____ Date:_____

WHITE COPY - CENTER YELLOW COPY - REIMBURSEMENT PINK COPY - PATIENT

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