Patient Data and Insurance - Please fill out completely

Patient's Name ____ Telephone # Day______________________ Cell____________________

Email_____________________ Social Security # ___________________D.O.B. ___________ Circle One: Male Female

Address____ City__________________State_______Zip__________

Primary Insurance __________________________________ Telephone # ____

Subscriber Name _____________________ ID # ______________________ Group # ________________________________

Patient Authorization/Assignment of Benefits/Release of Protected Health Information

Patient Signature Required for Proof of Delivery, Assignment of Benefits, Acknowledgement of Receipt of Privacy Notice, and Terms and Conditions of Agreement.

Company," when used in this agreement, refers to ______________________________________. "Patient," refers to the person receiving medical equipment and supplies.

I understand that the Company functions only as a supplier. I understand that this equipment is to be used only for my diagnosed condition and is issued under a doctor's prescription. I have been fully instructed on the use of this equipment and am aware of the warnings and precautions. I absolve the Company of any responsibility in the event of any accident or injury caused directly or indirectly in the use of rented or purchased equipment. I assign any and all rights and benefits of my insurance policy and any causes of action in order to collect from my insurance company to the Company. I further acknowledge my insurance carrier may send, directly to me, monies meant for reimbursement to the Company for services provided. In the event I receive this reimbursement, I agree to endorse and forward it to the Company within five (5) business days of the day of receipt. I am aware that the Company's policy is to pursue collection, to the fullest extent, of any reimbursement made for their service(s) which is not forwarded for payment by the Insured.

I authorize the Company to provide supplies needed based on my prescription from the physician. **I choose to use this particular equipment and this particular company.** Should my supplies become over/under-stocked, I understand that it is my responsibility to notify the Company. I understand that, because of health regulations, supplies are non-returnable due to contamination.

I hereby authorize and direct you, my attorney and/or insurance carrier, to pay directly to the Company, such sums that may be due for the medical services rendered. In the event that my insurance carrier has a preferred provider that is considered in-network, I instruct my insurance carrier to apply my out-of-network benefits. I hereby, further, give a lien on my case to the Company against any and all proceeds of any settlement, judgment or verdict that may be paid to you, my attorney or me.

I authorize my HealthCare Provider and the Company, the release of my medical records and information needed to determine benefits and or substantiate medical necessity. I also give authorization for the Company to appeal any denials of payment on my behalf with my insurance carrier. I permit a copy of this authorization to be used in place of the original. I understand that the Company Privacy Policy will be delivered to me with the device and I can contact patient relations at 1-800-211-4114 option number 2.

By my signature below, I acknowledge that I have read, understand and agree with the statements contained above and also acknowledge the receipt of the prescribed equipment.

To file a complaint against a health care facility, report Medicaid fraud, obtain information about AHCA or request a publication, call (888) 419-3456.

The Department of Children and Families – Abuse Hotline (800) 962-2873

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Patient (or guardian) signature Date