PROVIDER Rx & PATIENT PRODUCT AGREEMENT

Patient Information

Name:_____ Address_____

City_____ State_____ ZIP_____ Gender_____ DOB_____ Phone_____

Insurance_____ ID/Number_____

Provider:

NAME:_____NPI_____

Signature_____Date_____

Product Information:

PLACE STICKER HERE

If no sticker, please write in what was dispensed

PLACE STICKER HERE

If no sticker, please write in what was dispensed

DIAGNOSIS:

SIDE: ☐**LEFT** ☐**RIGHT**

Foot/Ankle: ☐ Ankle Sprain ☐ Ankle Contracture ☐ Fibula Fracture ☐ Foot Fracture ☐Plantar Fasciitis

Knee: ☐ Knee Sprain ☐Knee Derangement ☐Knee Instability ☐ Osteoarthritis ☐ Patella Fracture

Wrist/Hand: ☐Wrist Sprain ☐ Carpal Tunnel ☐Osteoarthritis ☐Finger/Wrist Fracture ☐Elbow Sprain

Back/Shoulder:☐Lumbar Sprain ☐Shoulder Sprain

Nebulizer: ☐ Asthma ☐ Bronchitis ☐Pneumonia ☐Restrictive/Reactive Airway Disease

Other ICD 10: _____ _____ _____

I have received, been instructed and educated on the proper usage of the medical equipment above for use at home according to the physician's description for my condition. The Following Has Been Explained/Reviewed with Patient: Equipment use instructions Home safety & home fire safety Costs and reimbursement Infection prevention and control Notice of privacy practices (HIPAA) Complaint process Patient rights & responsibilities Patient satisfaction Patient falls education Policy notification Victim abuse CMS standards.

ASSIGNMENT OF BENEFITS: I confirm that the information provided by me in applying for payment under Title XVIII (Medicare) of the Social Security Act and any other named insurance is true and correct. I request payments under my medical insurance program be made to Pro Medical East or affiliates on any unpaid bills for services furnished to me by Pro Medical East or affiliates. I certify that the address indicated under "Patient Information" is my permanent address as defined by the Centers for Medicare and Medicaid (CMS). **INSURANCE COVERAGE**: Benefits are based on insurance eligibility and coverage at the time of service. **RELEASE OF INFORMATION:** I authorize any holder of medical or other related information about me be released to Pro Medical East or affiliates for the purpose of determining benefits for related services and applying for payment. I authorize Pro Medical East or affiliates to release to CMS, its intermediaries, or commercial insurance companies and accrediting bodies' information needed for insurance claims in quality assessment purposes. This agreement consists of all the terms and conditions on this page and the reverse side whether printed or written. I certify that I have read the terms and conditions of this agreement and agree to be bound by such provisions. I accept full responsibility for all services rendered, including being informed of my rights, responsibilities, and complaint procedure. I have also been instructed on the safe and proper use of the equipment and/or supplies provided and agree to notify Pro Medical East or affiliates immediately when the medical necessity has ended. I have received or previously received a copy of Medicare Supplier Standards, Patient Bill of Rights, HIPAA Privacy Rights and a Customer Handbook from Pro Medical East or affiliates.

I, THE UNDERSIGNED, UNDERSTAND THAT I AM PERSONALLY RESPONSIBLE FOR ALL CHARGES NOT COVERED BY MY INSURANCE.

Patient/caregiver name_____ **Signature**_____ **Date**_____

(If signed by caregiver or other, list relationship and reason for signing) CHECK ONE ☐CARE GIVER ☐RELATIVE ☐OTHER_____

IN THE EVENT OF A GRIEVANCE I UNDERSTAND I HAVE THE RIGHT TO COMMUNICATE THOSE GRIEVANCES TO CMS MEDICARE 1-800-MEDICARE

FAX TO: 732-657-9400 WITH PATIENT FACE SHEET

Pro Medical East

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