Assist Home Care, Inc.

Assignment of Benefits

Patient: M|SITE.SHIP_TO_NAME Patient ID: M|CUSTOMER.PATIENT_ID
Address: M|SITE.SHIP_TO_ADDRESS|M M|SITE.SHIP_TO_CITY, M|SITE.SHIP_TO_STATE M|SITE.SHIP_TO_ZIP
Phone: M|SITE.SHIP_TO_PHONE_NUMBER

AUTHORIZATIONS: I hereby authorize and consent to the provision of products and/or services to me by Assist Home Care, Inc.. I understand that I am under the control of my physician and that Assist Home Care, Inc. is not liable for any act or omission when following the instructions of said physician. I authorize Assist Home Care, Inc. to contact me via mail, email or phone to inform me of special programs/sales related to or a logical adjunct of the products I have received.

PHI: I authorize the release/disclosure of my Protected Health Information (PHI)--any records pertaining to my medical history for products or services rendered--to be reviewed by Assist Home Care, Inc., the Centers for Medicare and Medicaid Services, my insurance carrier or other healthcare entities/providers involved in my care for purposes of determining benefits, processing a claim for payment, performance improvement, accreditation, certification, licensing or if required by federal, state or local law. Assist Home Care, Inc. may disclose my PHI to family or friends involved in my care, unless I refuse in writing. ***(See our Privacy Notice for full list of disclosures.)***

ASSIGNMENT OF BENEFITS: I authorize direct payment of Medicare, Medicaid, insurance and any other healthcare benefits to Assist Home Care, Inc. for authorized services/equipment furnished to me by Assist Home Care, Inc.. In the event payments for insurance benefits are made directly to me on an assigned claim, I will endorse all checks for such payments or otherwise reimburse Assist Home Care, Inc. the amount due.

AGREEMENT TO PAY / FINANCIAL RESPONSIBILITY: **All insurance verifications of coverage are based on plan provisions, and are not a guarantee of benefits. Assist Home Care, Inc. will submit your claim, but it remains your responsibility to make sure the claim is paid. We strongly recommend that you contact your insurance company to discuss your plan provisions and coverage.** While insurance or other coverage may exist for the Equipment provided to me by Assist Home Care, Inc., I understand that not all Equipment may be covered, or that reimbursement may be less than 100% of billed charges in accordance with my coverage. **Therefore, I agree to be financially responsible for any balance owed on my account including co-payments, coinsurance and deductibles, or even the full amount if the insurance company denies or recoups payment for services/equipment originally thought to be covered.** I understand that if I fail to notify Assist Home Care, Inc. immediately of a change in insurance carrier, and charges are not paid by the new carrier due to timely filing criteria, I will be financially responsible for the full amount not paid. Outstanding charges are due within 15 days from date of billing statement. Unpaid accounts will be sent to collections, with collection costs charged to the patient/legal agent.

RENTAL AGREEMENT: I understand that if I am renting equipment from Assist Home Care, Inc., the rented equipment remains the property of Assist Home Care, Inc., ownership will not be transferred until all amounts due Assist Home Care, Inc. are fully paid, and that the Equipment must remain within the service area unless written permission is given and documented by Assist Home Care, Inc.. I agree that if after reasonable notice I fail to pay any charge when due, Assist Home Care, Inc. may in addition to all other remedies which may be available, peaceably repossess the Equipment without legal process. I agree not to remove or alter any identification on the equipment or in way attempt to transfer such Equipment. Following the rental term, Assist Home Care, Inc. will extend a three-day grace period for the return of monthly rentals and a one-day grace period for weekly rentals. Full rental charges will be incurred after the grace period. **If you enter a hospital, nursing home or hospice care, or no longer medically need the rented equipment, you must notify Assist Home Care, Inc. immediately. Medicare, Medicaid and most insurance plans do not cover medical equipment while you are in the hospital, nursing home or under hospice care.**

RETURN/WARRANTY POLICY: Returns are accepted only within **14 days of purchase** with the original receipt, in the original, unopened and undamaged packaging. Products are **NOT RETURNABLE** if modified, used, custom-made, for personal care or worn against the body. Returns are subject to a 20% re-stocking fee. Assist Home Care, Inc. honors the manufacturer's warranty for new equipment and parts. Equipment without a specified warranty will be warranted for 30 days against manufacturer defect, not if damaged due to negligence or misuse. Labor and travel time are not covered under the warranty.

COVENANTS: This document represents the entire agreement between the parties and supersedes 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 Assist Home Care, Inc.. I agree this agreement will be binding on my heirs, representatives and assignees. I certify that all patient information provided to Assist Home Care, Inc. is true, complete and accurate. Note: a copy of this Agreement and Consent shall be considered the same as the original, and all authorizations will remain in effect until revoked in writing.

I hereby certify that: I am the patient/beneficiary, or am duly authorized to execute this Agreement and accept its terms on behalf of the patient; I have been given an opportunity to read this document, understand its terms and conditions, and have received a copy thereof; I have received, or been offered and declined, the Medicare Supplier Standards, Patient Rights/Responsibilities, Privacy Notice and Scope of Services. I consent to the release of my PHI as needed for the purposes of treatment, payment, legal requirements and healthcare operations.

Signatures

	M|DRIVER.FIRST_NAME M|DRIVER.LAST_NAME	M|C|CURRENTDATE
Patient or Patient's Representative	**Company Representative**	**Date**

Relationship to Patient: (if not 'Self')
Reason Patient Could Not Sign:

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