Assignment of Benefits/Terms and Conditions

AUTHORIZATION/CONSENT FOR CARE/SERVICE: I have been informed of the home care options available to me and of the selection of providers from which I may choose; and I have Insurance Covered Compression Therapy, a MedSource, LLC Company ("Company") as my provider. I authorize Company to provide compression therapy products, supplies, and other products as prescribed by my physician and authorized by my insurance provider (collectively the "Services").

ASSIGNMENT OF BENEFITS/AUTHORIZATION FOR PAYMENT: I authorize Company to directly bill Medicare, Medicaid, Medicare Supplemental, or other insurer(s) on my behalf, for the Services furnished to me by Company; and I assign my rights and benefits from such insurers to Company.

RESPONSIBILITY TO ADVISE OF CHANGES: I acknowledge that the coverage Company has quoted to me is based upon information provided to Company by me and will be based upon my coverage eligibility at the time of delivery of the Services. I agree that it is my responsibility to notify Company of any changes to my insurance prior to receiving the Services in order to avoid my incurring of any additional charges for non-covered Services.

PRIVACY NOTICE: I have received and reviewed the Privacy Policy.

PROVIDING INFORMATION: I am responsible for providing all necessary information and for making sure all certification and enrollment requirements for insurance coverage are fulfilled. I will report any change in my insurance coverage to Company within ten (10) days of such change.

RELEASE OF INFORMATION: I authorize any holder of medical information about me to release to Company my physician(s), caregiver, CMS, its agents and to primary and/or other medical insurer any information needed to determine or secure eligibility information and/or reimbursement for covered Services. I authorize Company to obtain medical or other information necessary in order to process my claim(s), including determining eligibility and seeking reimbursement for medical supplies provided.

FINANCIAL RESPONSIBILITY: I am responsible for the payment of all deductibles, co-payments, out-of-pocket requirements, and non-covered Services. In the event my insurer denies coverage, I hereby agree to pay for such Services provided by Company within thirty (30) days of receipt of an invoice. I agree that I am responsible for all late fees, interest and reasonably collection costs (including attorney's fees) for any invoice not paid within thirty (30) days of receipt.

I acknowledge my responsibility for all the aforementioned charges, unless my agreement with my insurer holds me harmless from such charges.

RETURNED GOODS**:** Due to Federal and State laws and regulations ancillary items prescribed for home health care cannot be re-dispensed and cannot be returned for credit. Sale items cannot be returned.

CONSENT TO BEING CONTACTED BY Company: I consent to receive, live or automated, phone calls, e-mails, texts, and pre-recorded messages from Company regarding products and services, at the phone number(s) or email address I have provided. I acknowledge email is not a secure means of communication and my protected health information that may be contained in my emails to Company will not be encrypted. This means that there is risk that my protected health information in the emails could be intercepted and read by, or disclosed to, unauthorized third parties. I further acknowledge that use of alternative and more secure methods of communication with Company, such as telephone, fax or the U.S. Postal Service are available to me.

COMMUNICATION WITH MINORS**:** We are committed to protecting the privacy of children. Company's websites and ordering ability are not available to users under the age of 18. If you are under the age of 18, you are not permitted to register with Company, submit personal information, or place orders.

Information for Medicare Patients

The Services offered and provided by Company are subject to the supplier standards contained in the federal regulations shown at 42 Code of Federal Regulations Section 424.57(c). These standards concern business professional and operational matters (e.g., honoring warranties and hours of operation). The full text of these standards can be obtained at http://ecfr.gpoaccess.gov. Upon request Company will furnish you a written copy of the standards.

AGREEMENT TO TERMS AND CONDITIONS: I am the patient or the patient's authorized representative and agree to the Terms and Conditions contained in this form and any other documentation provided by Company.

ABOUT FINANCIAL ARRANGEMENTS AND HEALTH INSURANCE: We are committed to providing you with the best possible care. If you have medical insurance, we are committed to helping you receive your maximum allowed benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payment for Services is due at the time Services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, checks, & most major credit cards. We will be happy to help you process your insurance claims for reimbursement of the Services. Balances older than ninety (90) days may be subject to additional collection fees and interest charges of 1.5 % per month. We must emphasize that, as healthcare providers, our relationship is with you, not your insurance company. While the filing of the insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the Services are rendered.

We realize that temporary financial problems may affect timely payment to your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. If you have any questions about the above information or any uncertainty regarding your insurance coverage, don't hesitate to ask us. We are here to help you.

Patient Signature:_____ Date:_____