



PATIENT ACKNOWLEDGMENT

YOUR COMPANY NAME

Please initial the following:

I acknowledge receipt of/or have been offered a copy of the following information:

- ____ Company Financial Policy
- ____ HIPAA (Notice of Patient Privacy Right)
- ____ Medicare Supplier Standards

Communication Authorization

I authorize Insert Company Name to leave messages on my home phone/cell phone or contact me by e-mail at _____.

I permit Insert Company Name to collect my health care information from my physicians in order to receive payment for their services for my device.

Delivery Acknowledgement

- ☐ This is to **certify** that I have received my device as prescribed by my physician and I am satisfied with the device.
- ☐ I have received instructions on the function, care, use maintenance and precautions of my device.
- ☐ I have been scheduled for a follow-up appointment or informed when to call for a follow-up appointment as appropriate to my device.
- ☐ I have been informed of the warranty policy.
- ☐ I have been informed if I have any issues or discomfort with my device to call the company.

Payment Authorization

- ☐ **I assign** the right and responsibility to Insert Company Name to bill my insurance carrier on my behalf and accept payment for my device.
- ☐ **I authorize** my insurance carrier to make payment to Insert Company Name
- ☐ **I accept** responsibility for my coinsurance and my deductible on this device

Patient Signature/Representative: _____ **Date:** _____

These forms are provided by ABC for your use. Please feel free to change and/or customize them to suit your business needs.

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