Patient Awareness Sheet

(*to be completed and returned with signed RSA)*

I , _____(patient name) hereby authorize Rehab Supply LLC and its staff to provide me with Durable Medical Equipment that has been prescribed by my physician who has explained the nature of this treatment and I have received all of the information I desire.

1) I do not knowingly have tuberculosis or any other serious respiratory or blood borne disease that has not been disclosed to Rehab Supply. I understand that this is protected health information and shall be held in the strictest confidence by all Rehab Supply. This information is requested as a protection to Rehab Supply staff and other patients only.

2) It is my responsibility to confirm my insurance coverage for durable medical equipment. (Customer service 1-800#s are located on the back side of most insurance cards). My insurance coverage is dictated by my individual contract and not by Rehab Supply. My insurance may have a co-payment or a deductible that is my financial responsibility. I understand and agree that regardless of my insurance coverage and potential reimbursement, that I am accepting full and complete financial responsibility for the equipment provided by Rehab Supply detailed on my signed Rental Sales Agreement (RSA). I may contact Rehab Supply at 800-485-9717 ext 231 to discuss charges.

3) I hereby authorize direct payment of DME insurance benefits to Rehab Supply for services rendered by them. I have filled out the patient portion of the RSA form completely writing "none" in any blank space. I have provided complete insurance and employment information, mailing address, and phone numbers to Rehab Supply. If my insurance is Medicare, I have provided a copy of my insurance card to insure claim will be submitted using the correct insurer name.

4) I understand that any billing services provided by Rehab Supply are done as a convenience to me and do not release me from financial liability for the services and equipment supplied by Rehab Supply. Further it is my responsibility to notify Rehab Supply of any changes in my insurance coverage or financial responsibilities that would directly impact the payment of the prescribed equipment.

5) I authorize the release of my medical and/or billing information to Rehab Supply, my insurance carrier(s), spouse, family, children, parents, guardian, attorney, physician, employer, and/or physical therapist. I permit a copy of the authorization to be valid as the original.

6) I understand that most insurance carriers require an initial rental phase of 2-12 months before conversion to purchase. I understand that if I receive a request form for Certification of Medical Necessity (CMN) and feel the equipment is helping me I will visit my doctor to complete the form indicating my desire to convert the rental to a final purchase otherwise I am responsible to return the unit to Rehab Supply.

7) I have received a copy of Rehab Supply Important Client Information & Rights Sheet which contains- A) Customer Service Contacts, B) After-hours Service, C)Compliant Procedure D)Proper Training E)Return Policy F)Payment G) Client Bill of Rights H) Notice of Privacy Practices and I) CMS Medicare DMEPOS Supplier Standards.

8) I understand and have been instructed on the prescribed usage of the durable medical equipment provided to me. I will take full responsibility for its use and care in my home. If I choose to discontinue its use, I will do so after advising my physician. I shall not hold Rehab Supply responsible for any adverse consequences of any misuse, failure to use, or discontinuation of use of the durable medical equipment provided to me. I understand I'm still responsible for any incurred charges up to the point of the discontinuation and return of the equipment under the rental agreement.

9) I understand that once the equipment has met purchase price and/or has been converted to sale, it cannot be returned to the Rehab Supply for a credit, refund or exchange.

10) I understand that every product sold or rented by Rehab Supply carries a 1 – year manufacturer's warranty. Rehab Supply will notify all Medicare beneficiaries of the warranty coverage, and will honor all warranties under applicable law. Rehab Supply will repair or replace, free of charge, Medicare-covered equipment that is under warranty. In addition, an owner's manual with warranty information will be provided to beneficiaries for all durable medical equipment where this manual is available. I have been instructed and understand the warranty coverage on the product I have received.

Signature of patient (if not a minor) _____ Date_____

Signature of parent / guardian _____Relationship to patient _____Date_____