TRI- COUNTY MEDICAL & OSTOMY SUPPLIES, INC.

1904 Knob Creek Rd., Suite 1
Johnson City, TN 37604
423-282-6933

Patient Name: _____ SS# _____ DOB: _____

This form is designed to show that you acknowledge receipt of our orientation packet and to confirm your understanding of its contents and agree to its terms by signing below. I permit a copy of this authorization to be used in place of the original.

* **SUPPLIER STANDARDS:** I hereby acknowledge that I have received a copy of the Supplier Standards set forth by Medicare regulations.

* **PATIENT RIGHTS AND RESPONSIBILITIES:** I hereby acknowledge that Tri County Medical and Ostomy Supplies, Inc. has made me aware of my Rights and Responsibilities as a patient.

* **AUTHORIZATION FOR TREATMENT/RELEASE OF INFORMATION:** I hereby give my permission to this company to perform all necessary procedures pertinent to my physician's orders, for the delivery of healthcare services. I consent to receive services from Tri County Medical and Ostomy Supplies, Inc. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I request that payment of authorized Medigap/insurance benefits be made either to me or on my behalf to Tri County Medical and Ostomy Supplies, Inc. for any services furnished me by that provider. I authorize any holder of medical information about me to release to my Medigap/insurance any information needed to determine these benefits or the benefits payable for related services. I authorize any holder of medical and/or insurance information about me to release this information to Tri County Medical and Ostomy Supplies, Inc. upon request, for services rendered. This authorization applies to all occasions of services until it is revoked

* **PRIVACY NOTICE ACKNOWLEDGEMENT:** I hereby acknowledge that I have been provided with a copy of the company's notice of Privacy Practices. In accordance with the privacy regulations of the Health Insurance Portability and Accountability Act (HIPAA), the Notice of Privacy Practices describes the company's legal responsibilities with respect to my protected health information and it describes my right under the HIPAA Privacy Regulations.

* **ASSIGNMENT OF BENEFITS:** I request that payment of authorized Medicare/insurance benefits be made either to me or on my behalf to Tri County Medical and Ostomy Supplies, Inc. for any services furnished to my be that supplier.

* **EQUIPMENT DELIVERY/TRAINING:** I hereby state that my designated party or I have received the medical equipment/supply in good working condition. I also state that I received and understand proper education and training by a qualified staff member of Tri County Medical and Ostomy Supplies, Inc. I accept responsibility for the loss or damage to the equipment resulting from negligence, theft and abuse or accident. I agree the equipment remains the property of Tri County Medical and Ostomy Supplies, Inc. and will be returned when no longer medically necessary, unless otherwise noted. If I do not return the equipment, I will be responsible for the payment to replace the item. I release Tri County Medical and Ostomy Supplies, Inc and all employees and owners of any and all liability connected with the use or installation of the equipment should an accident occur.

* **STATEMENT OF FINANCIAL RESPONSIBILITY:** I understand that my insurance can be billed as a courtesy even though Tri-County Medical and Ostomy Supplies, Inc. may not be contracted with my insurance and that there is no guarantee of payment by my insurance company. I understand that I am personally responsible for any deductible, co pays or non-covered charges applied by my medical insurance (this includes charges accrued due to changes in insurance that we are not notified of prior to billing your insurance or charges accrued if you are receiving home health care services and your insurance does not cover supplies or equipment during these dates of service.) I agree to reimburse Tri County Medical and Ostomy Supplies, Inc. any portion of payment made directly to me by my insurance company for unpaid balances owed to Tri County Medical and Ostomy Supplies, Inc. The terms are net 30. A late charge of 1.5% per month will be assessed on all unpaid balances after 30 days. Should any unpaid balance be turned over to a collection agency, I will be responsible for all collection fees, attorney fees, court costs, etc., involved in this action.

PATIENT SIGNATURE:_____ DATE: _____

RESPONSIBLE PARTY/LEGAL GUARDIAN:_____ RELATION: _____

COMPANY REPRESENTATIVE:_____ DATE: _____