

Prism Medical Products, LLC.
1328 North Bridge Street
Elkin, NC 28621
Phone/Fax: 1-800-975-6321

PLEASE SIGN AND RETURN **AUTHORIZATION and AGREEMENT FOR SERVICES**

HOME HEALTH CARE

I understand that these supplies are not covered if I am receiving any kind of Home Health Services. These supplies must be provided by my Home Health Service Provider. If I choose to accept them while under a Home Health Episode, as defined by CMS, I may be financially responsible for the cost of these items.

RIGHTS AND RESPONSIBILITIES

My signature below acknowledges that I have received the statement of rights and responsibilities and it has been explained to me.

AUTHORIZATION FOR SERVICES

I authorize **PRISM MEDICAL PRODUCTS, LLC** to provide supplies and/or services as ordered by my physician. I understand that I have the right to make decisions concerning my medical care, including the right to accept or refuse medical or surgical treatment or medical supplies.

PATIENT HEALTH INFORMATION AND SUPPLIER STANDARDS

My signature below acknowledges that I have received the brochure explaining **PRISM MEDICAL PRODUCTS, LLC's** patient health information privacy policy and CMS (Medicare) Supplier Standards.

ASSIGNMENT OF BENEFITS

I authorize payment directly to **PRISM MEDICAL PRODUCTS, LLC** of any benefits otherwise payable to examination or treatment of client. I agree to pay any charges not covered by insurance benefit plans, excluding Medicare and Medicaid recipients and where payment is prohibited by law. Primary Insurance pays for 80%. Client is responsible for 20% of approved charges and any unpaid annual deductible. **I understand that Medicare or my primary insurance will only cover for products it deems "medically necessary" and payments made by Medicare is based on their regulations, utilization limits and fee schedules.**

EMERGENCY PLAN

My signature below acknowledges that I have established and understand my emergency plan. I have received **PRISM MEDICAL PRODUCTS, LLC's** brochure; I have informed of the nature and procedure to request additional supplies I may need; and I have participated in the planning of my care. There are no home visits appropriate for the care provided.

RELEASE OF INFORMATION

I certify that the information given by me in applying for payment under Title XVIII of the Social Act, or under a policy of insurance is correct. I authorize the home care company or any other holder of medical or other information about the above named client, to release or receive such information to any government agency or insurance company to whom application has been made for payment for services rendered to the above client; to any physicians, hospitals, other healthcare providers or facilities, institutions, or agencies providing treatment to the client or providing continuity of care; and to quality reviewers.

PRODUCT WARRANTY

All supplies distributed by Prism Medical Products, L.L.C. are guaranteed to be free from any defect. Any beneficiary that reports a defective product may return it within 10 business days to be replaced, free of charge. In addition, where applicable, directions for use and warranty information will be provided to beneficiaries for all products provided. Any remaining sealed supplies may be returned within 30 days for credit to the account. I have been instructed and understand the warranty coverage on the product(s) I have received.

Beneficiary's Signature or Person Responsible for Beneficiary

Date

Beneficiary's Name (Printed)

Date of Birth