

SMA MEDICAL SUPPLY

329 WHISPERING TRAILS ST. ARGYLE, TX 76226

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AUTHORIZATION TO ASSIGN BENEFITS TO PROVIDER

I, the undersigned, request that payment of authorized Medicare, Medicaid or any other government benefits or private insurance benefits be made on my behalf to *S.M.A. Medical Supply* for any products or services that they have provided to me.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I, the undersigned, authorize any holder of medical information about me to release to *S.M.A. Medical Supply* or to the Healthcare Financing Administration and its agents any information needed to determine benefits payable for related services, or the process of claims on my behalf. This authorization is in effect until I choose to revoke it.

PRIVACY NOTICE

I, the undersigned, have received a copy of and reviewed the privacy practices of *S.M.A. Medical Supply* as it relates to HIPPA.

WARRANTY POLICY

I, the undersigned, acknowledge that *S.M.A. Medical Supply* honors the manufacturer warranty for equipment sold and that this warranty does not cover abuse, misuse, or neglect of equipment.

PROPER USE OF EQUIPMENT

I, the undersigned, do fully understand that equipment provided by *S.M.A. Medical Supply* is intended for a single patient's use within the parameters set forth by their Physician, therapist, or other certified medical provider. I have received, or will be receiving, from the prescribing physician, certified therapist or specialist, proper instruction on the use of equipment provided to me by *S.M.A. Medical Supply*. I further understand that *S.M.A. Medical Supply* is strictly an equipment provider and does not make home visits or staff any certified, licensed, or credentialed medical personnel. I will not hold *S.M.A. Medical Supply* responsible, in any way, for my use of the equipment or supplies sold to me, or for any medical consequences resulting from my use of the equipment/supplies.

CHARGES AGREEMENT

I, the undersigned, do fully understand that I am personally responsible for the rental and purchase charges of the equipment or supplies provided to me until or unless payments are made directly to *S.M.A. Medical Supply* by a third party payer. I also understand that I am responsible for the full amount of the charges if the third party payer denies payment for any reason. I agree to reimburse *S.M.A. Medical Supply* for any unmet deductible as well as any co-insurance payment.

By signing below, I hereby indicate that I have read and understand that entire contents of this document. This agreement remains in effect until I choose to revoke it in writing.

Patient signature or signature of responsible party

Relationship to patient

Date