FLEX *Orthopedic Services, L.P.*
Toll Free Phone: 877.582.4939

PHYSICIAN PRESCRIPTION/PATIENT AGREEMENT/PROOF OF DELIVERY

Location_____

Patient Name:_____ **Date of Visit:**_____ **Date of Injury:** _____

Address: _____ **City:**_____ **Zip:**_____

Home:_____ **Daytime Phone:**_____ **Email:**_____

Referring Physician: _____ **Extremity:** ☐ Left ☐ Right ☐ Bilateral

Insurance Co.:_____ **Policy Holder:**_____ **Policy Holder's DOB:**_____

Policy Number:_____ **Group Number:**_____

Diagnosis/ICD-9:_____ **Vendor:** _____ **Quantity:**_____

Part Number or Bar Code Label Here

Patient Date of Birth:_____

Product Description:_____

Ordering Physician Signature:_____ **Date:** _____

PATIENT PROOF OF DELIVERY:

THIS IS TO CERTIFY THAT I HAVE RECEIVED THE ABOVE LISTED ITEM OR SERVICE. I AM SATISFIED WITH BOTH THE WORKMANSHIP AND FIT OF MY DEVICE AND I HAVE BEEN FULLY ADVISED AS TO THE CARE, USE AND WEAR OF THE DEVICE(S).

I have read and agree to the terms and conditions stated herein:

Assignment of Benefits:
As a courtesy to the patients and their families, DME Supplier* does submit a claim to many third party payers. I request that payment of authorized Medicare or private benefits be made to DME Supplier for any covered services furnished to me by DME Supplier. If my insurance carrier pays me directly, I agree to forward all funds to DME Supplier within ten (10) business days. I agree that I am responsible for paying all non-covered or unpaid amounts unless otherwise provided by law, regulation or DME Supplier contractual relationships. I agree to be responsible for the full amount of the charges from the date of delivery which my third party payer does not pay for in a timely manner, or if I fail to provide within ten (10) days the information necessary to submit the claim for payment.

Disclosure of Information:
I understand that my medical records and billing information are made and retained by DME Supplier and are accessible to DME Supplier personnel, who may use and disclose medical information for DME Supplier operations and functions and to any other health care personnel, involved in my continuum of care for this product.

Release of Records:
I understand that my medical records and billing information are made and retained by DME Supplier and are accessible to DME Supplier personnel, who may use and disclose medical information for DME Supplier operations and functions and to any other health care personnel, involved in my continuum of care for this product.

I hereby authorize my ordering physician to release all medical records pertaining to my healthcare information to DME Supplier. I understand further that the information, authorized for release may include records which contain the diagnosis of communicable diseases.

Acknowledgment of Notice of Privacy Practices:
A complete description of how my medical information will be used and disclosed by DME Supplier has been given to me in DME Supplier HIPAA compliant NOTICE OF PRIVACY PRACTICES. I have been given the opportunity and have been advised to read the notice prior to signing this Consent Form. If I have questions, I know to contact the Privacy Officer whose information is provided to me in the Notice of Privacy Practices.

Certificate of Medical Necessity/Letter of Medical Necessity:
The above modalities are required during the normal course of patient rehabilitation in order to protect the injury and/or surgical repair. These modalities will allow the patient to resume normal activities of daily living more quickly and at less cost. These modalities are an essential part of our post-operative and/or post-injury treatment and are prescribed to preserve the integrity of the surgical procedure and/or prevent further damage to the site.

Please list any names of persons with whom DME Supplier can discuss your health care information. (Optional)

Name: _____ Relationship: _____

_____ _____

Patient (or Parent/Guardian or Representative) Date

_____ _____

Relationship to Patient Witness

Rep_____