PATIENT FINANCIAL AGREEMENT ***(must be signed and dated by responsible party)***

Print Name _____

Proof of Delivery: *The patient or responsible party("I") acknowledges receipt/proof of delivery of the Durable Medical Equipment specified on this Standard Written Order. I do confirm on this day I am in receipt from Advanced Technology of Kentucky Inc. ("ATI") or an Advanced Technology of Kentucky Inc. affiliate ("Provider"), the product listed about and participated in the plan of care. I confirm I have also been provided (1) written and verbal instructions on proper use, care and maintenance of the product provided; (2) access to the Medicare Supplier Standards; (3) access to the Patient Bill of Rights; (4) Provider's Notice of Privacy Practices; (5) warranty information; (6) return policy; and (7) contact information for questions or complaints.*

Refusal: *I understand that I may refuse delivery of this product.*

Consent for Treatment: *I consent to treatment by the Provider. I understand and agree that (1) my care is under the supervision and control of my attending physician; (2) my physician has prescribed the product and services delivered to me today as part of my treatment; (3) my physician has explained the risks, advantages, complications and alternatives to this product. (4) my physician has explained why this treatment is considered medically necessary as treatment for my condition (5) the Provider's services do not include diagnostic testing, prescriptive rights and other functions pertaining to licensed physicians; and (5) only my physician is solely responsible for diagnosing and prescribing drugs, product and therapy for my condition or otherwise supervising and controlling my medical condition.*

Assignment of Benefits: *I consent to billing by the Provider and request any payment authorized by Medicare, Medicaid, supplemental insurance, Medigap, and/or other third-party insurance policies which is made on my behalf be directed to the Provider for the products delivered to me on this date.*

Release of Information: *I agree to provide all documents and information necessary for the Provider to obtain direct payment from Medicare, Medicaid and/or other third-party payers. I hereby authorize the release of my medical information to determine and obtain insurance benefits for products and services provided to me by the Provider. I authorize the Provider to appeal denied insurance authorizations or benefits on my behalf.*

Financial Responsibility: *I understand and agree that (1) I am financially responsible to the Provider for payment of applicable deductibles, co-insurance, or other amounts assigned by Medicare, Medicaid and other third-party payers as my financial responsibility; (2) I am financially responsible for any product or services delivered to me that are not reimbursed by Medicare, Medicaid and/or other third-party payers; unless otherwise prohibited by contract or law; (3) any amount owed will vary based on my insurance plan, whether my deductible has been reached, if I have co-insurance amounts, if an item is reimbursable by my plan, network status of my plan, and/or if I have secondary coverage; (4)I agree to transfer immediately to the Provider any payments made to me directly from Medicare, Medicaid, and/or other third-party payers for the products and/or services provided to me in whole or in part; and (5) if I am unable to pay my responsibility in full, I will contact the Provider at the information listed above to establish a payment plan and/or apply for income-based financial assistance.*

Email and Cell Phone Acknowledgment: *By providing my email and cell phone information I (1) authorize the Provider to contact me by those methods regarding the care and services I have received; (2) my information will not be used or sold for any other purpose. Portions of the correspondence may not be encrypted; therefore, the Provider cannot ensure the security of any information sent or received via email or text (4) will refer any questions regarding my rights to the Providers Notice of Privacy Practices.*

Patient/Responsible Party Signature: _____ _____Date: _____

Relationship to Patient: _____