Client's Name: _____DOB: _____DATE:_____

Assignment of Benefits

I authorize direct remittance of payments of all insurance benefits, including Medicare, Medicaid, or any third party insurance provider benefits, for all covered medical supplies provided to me by Professional Healing Solutions. I understand and agree that this Assignment of Benefits will have continuing effects for so long as I am being supplied. I have the right to revoke this consent at any time by submitting written notice to PHS. Revocation will not affect any action PHS took in reliance on this consent before receiving my notification, and PHS may decline to supply me or to continue to supply me if I revoke this consent. A photocopy of this assignment is to be considered as a valid original.

Authorization to Release Information

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment, supplies or services to the organization, to PHS and/or my insurance carrier and its agencies and/or other authorized representative. Other than you, your insurance carriers, and other medical providers involved in your care, please indicate below anyone else that we may discuss your PHI, (personal health information) including insurance benefits and bills from PHS with on your behalf:

_____

Name/Relationship Name/Relationship

Financial Responsibility

I understand that insurance billing is a service provided as a courtesy and I am financially responsible to Professional Healing Solutions for any charges not covered by my health care benefit. In the event that my insurance company should deny any of my claims, my signature stands as authorization to PHS to appeal any or all claims that are denied by my insurance, on my behalf, up to the allowed number of appeals granted by my insurance. After all appeals have been submitted by PHS and the outcome of denial is still the decision made by my insurance, I understand that I am financially obligated to pay the balance in full. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim (estimated benefits and charges are available upon request).

Delivery/Acceptance

I accept delivery unassigned or in person or via UPS/ FEDEX of all wound care supplies as prescribed to me by a physician per the attached Physician's written order or prescription. I have received instructions concerning the same, a copy of the Client's Bill of Rights and Responsibilities, and the HIPAA Policy. Your signature below indicates that you have read the above consent and have reviewed the Notice of Information Practices. You may use this consent form to request a restriction for information that you wish withheld related to your treatment, payment for service, or for the health care operations of Professional Healing Solutions LLC.., Please do so after reading the attached Notice of Information Practices. If I am a Medicare patient, I have received a copy of the Medicare Supplier Standards. My signature below is evidence of the receipt of the said documents and assignment of benefits. I understand any product received in my home, opened or unopened, cannot be returned.

Choice of Acknowledgement

I am free to choose the supplier that best fits my needs. Other sources are available in my area. I have read and understand the above information regarding my right to choose a supplier. I have been advised I have the option to choose any supplier for wound care supplies prescribed by my physician. I have chosen to receive my wound care supplies from the following source:

_____Professional Healing Solutions, LLC or Other Source:_____

Signature of Client/Authorized Representative:_____ Reason Client Unable to Sign:_____

Relationship to Client:_____ Authorized Rep Phone Number:_____