AtHome Medical

Assignment of Benefits, Authorization for Release of Information and Patient Payment Responsibility Notice of Privacy Practices

AHM000008

Account No.

200 American Road • Morris Plains, NJ 07950 • 800-287-0643 • Fax: 973-538-2703

Patient's name: HICN #

Patient's address:

Release of Information

I hereby authorize the holder of medical or other information about me to release to the Social Security Administration, Centers for Medicare and Medicaid Services and its intermediaries accreditation or regulatory agencies, or to any third party payer, as required, any information needed for this or a related health claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the party who accepts assignment.

I hereby authorize any medical facility, healthcare provider or other holder of medical information pertaining to me to release this information to **AtHome Medical** or their representatives so that **AtHome Medical** is able to prepare claims for submission on my behalf to Medicare, Medicaid or other third party payers.

Assignment

I authorize **AtHome Medical** to submit claims to Medicare, Medicaid, and/or commercial insurance carriers for payment. I request that payment of authorized Medicare, Medicaid or third party benefits be made either to me or on my behalf to **AtHome Medical** for any services furnished me by that supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services or third party insurance company or their agents any information needed to determine these benefits or the benefits payable for related services.

Patient Responsibility

I hereby guarantee payment to **AtHome Medical** for any and all charges not covered by this assignment, and waive any and all notices and demands in the event of non-payment there under. I am aware that **AtHome Medical** will bill me for all deductible and co-pay charges on all equipment and/or supplies that I have rented and/or purchased each month. I also agree that all rental equipment will be returned to **AtHome Medical** in good condition exclusive of normal wear through usage. I agree to compensate **AtHome Medical** for any loss due to misuse, lost, stolen or damaged property. I hereby certify that I have read or have had this document read to me. I understand its content and intent, and with my signature so execute my permission, effective as dated.

Protected Health Information

I have received a copy of the Notice of Privacy Practices for Protected Health Information (the "Notice"). This Notice provides a complete description of the uses and disclosures of my Personal Protected Health Information ("PHI"). I have had an opportunity to review this information before signing this form. I consent to Atlantic Health Systems participating in my care releasing my PHI (either in writing or verbally) to carry out treatment, payment or health care operations. This includes any medical information, which may be needed to process claims for medical insurance (or managed care) benefits relative to medical services (including pre-certification and verification, if necessary), or which may be needed to conduct continued care planning. I understand I may restrict how the PHI is used or disclosed. While Atlantic Health Systems will make every effort to comply with my request, it is not required to agree to the restriction.

I acknowledge receiving a copy of the **AHS Notice of Privacy Practices**.

(Signature of Patient) (Date)

by:

(Signature of authorized representative) (Date)

(Full address of person signing on behalf of the patient. **Note: Do not write "same"**)

(Relationship to patient) (Reason patient unable to sign)