Patient Agreement

Authorization for Release of Information
Assignment of Benefits and Deductible/Co-Pay Responsibility

Release of Information: I herby authorize the holder of medical or other information about me to release to the Social Security Administration, Centers for Medicare and Medicaid Services, its intermediaries 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 also authorize release of medical information to my physician(s), other health care providers to assist in my treatment, auditors authorized by Lantz Medical for the purposes of certification, licensure or accreditation and to the following:

individuals who may be involved in assisting in my affairs: _____ _____

I understand that I have the right to revoke and or restrict the use of this consent by notifying Lantz Medical in writing and that prior to signing this consent I have received and have had the opportunity to review Lantz Medicals privacy policy.

I also understand that I have right to access my health information, request that Lantz Medical amend health information, and the right to request an accounting of all disclosures of my health information.

Assignment of Insurance Benefits: I certify that the information given by me is correct. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for covered services rendered by Lantz Medical to Lantz Medical or its billing agent. I also authorize Lantz Medical or its billing agent to submit claims to Medicare, Medicaid, and/or commercial insurance carriers for payment. I authorize payment of my insurance benefits to Lantz Medical or its billing agent, which payment will not exceed the balance due on my account. I hereby guarantee payment to Lantz Medical or its billing agent of 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 have been notified by Lantz Medical or its billing agent that he/she believes that, in my case, my insurance carrier is likely to deny payment for the items identified below, for the reasons stated. If my insurance denies payment, I agree to be personally and fully responsible for payment.

Items likely to be denied include: _____

I am aware that Lantz Medical or its billing agent will bill me for my deductible and co-pay charges on equipment and/or supplies that I have rented for payment each month. I agree to immediately remit to Lantz Medical any payments I receive directly from any source for services provided to me by Lantz Medical. I agree the rental equipment remains the property of Lantz Medical and will be returned in good condition when no longer necessary. I hereby certify that I have read or have had this document read to me, and I understand its contents and intents, and with my signature so execute my permission.

PATIENT INFORMATION		INSURANCE INFORMATION	
Name :		Insurance Co :	
Address:		ID# :	Grp# :
City/State/Zip :		Address :	
SSN:	DOB :	City/State/Zip :	
Telephone: ( )	Alt # : ( )	Claim # :	
Employer:	Work#: ( )	Phone# : ( )	Contact:

SECONDARY INSURANCE	MEDICARE INSURANCE	MEDICAL INFORMATION
Ins. Co.:	County of Residence:	Physician:
Address:	Insured Name:	Phone: ( )
Phone: ( )	Medicare#:	Surgery Date:
Insured Name:	Surgery Date:	Diagnosis:
SSN:	Date Applied in Hospital:	
ID&Grp # :	Date of Discharge:	

EQUIPMENT INFORMATION

Rental or Purchase	SERIAL #	MODEL	QTY or EST DAYS USAGE	RATE

Your Deductible $_____ Patient Co-insurance responsibility _____%
My Benefits and potential financial responsibility have been explained to me. I understand this information is provided to me as a courtesy and I further understand there is no guarantee of benefits.

_____ _____ OR _____ _____
Customer/Patient Signature Date By Representative (If patient is unable to sign) Date

Would you like to have a copy of your signed *Patient Agreement* and *Plan of Care & Orientation Form* mailed to you? ☐ Yes ☐ No

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