Assignment of Benefits Agreement and Consent Form (AOB)

Patient Name: _____

Identification Number: _____

Patient Address: _____

_____

Patient Phone Number: _____

REQUEST FOR PROVISION OF SERVICES: I understand that by signing this agreement, I indicate my desire to purchase product(s) and services from Method HCS. I understand that product(s) and services received are not from or part of any hospital service, and that I will be billed separately by Method HCS.

ASSIGNMENT OF INSURANCE BENEFITS: I authorize Method HCS to request payment on my behalf for insurance or other medical benefits payable for any and all current or future items or services provided to me by Method HCS and hereby assign and transfer to Method HCS any and all rights to receive any insurance or other medical benefits otherwise payable to me, on my behalf, for those same items and services, including the following products or services listed or any other products or services provided by Method HCS: LSO, Knee, Shoulder, Wrist, Ankle and Foot Orthoses. I authorize my insurance company(ies) or other payors of medical benefits, to furnish Method HCS and /or its agents any and all information pertaining to my insurance benefits and/or the status of any claims submitted by Method HCS.

In the event that my insurance carrier or other payor does not accept an "assignment of benefits," I understand that all correspondence and payments for Method HCS may be sent directly to me. I agree that when such payments are received, I will promptly submit them to Method HCS for payment of my bill. I understand that I can make payments for services either by personal check or by endorsing the insurance payment to Method HCS by writing "pay to the order of Method HCS" and placing my signature under that endorsement.

ACCEPTANCE OF FINANCIAL RESPONSIBILITY: Not withstanding anything set forth above, I agree that I am responsible for and will promptly pay on demand any and all obligations to Method HCS including all self-pay balances as well as those charges for services not covered or disallowed by my insurance carrier.

The undersigned certifies that he/she has read the foregoing and retained a copy. The undersigned also certifies that he/she is the patient or is duly authorized by the patient to execute the above and accept its terms. I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries and/or insurance carriers any information needed for this or a related Medicare/Insurance claim. I permit a copy of this authorization to be used in place of the original and request payment of the medical insurance benefit to me.

NOTE: A duplicate copy of this Assignment of Benefits Agreement and Consent shall be considered the same as an original. This Assignment of Benefits Agreement and Consent shall remain valid and binding until revoked in writing by the undersigned.

X _____ _____

Signature (Patient) Date Patient Agent or Representative (if applicable)

X _____ _____

Witness Date Relationship to Patient (if applicable)

****Office purposes only****

Method HCS Employee # _____ Date _____

Method HCS Instructions: Complete one form for each consumer enrolled and SCAN FORM into EBridge.

Do NOT scan form without a valid signature.

GENERAL AGREEMENT

I authorize METHOD HCS to assist me and perform the duties as a holder of medical or other information about me to release to the Social Security Administration and the Centers for Medicare and Medicaid Services or its intermediaries or carriers any information needed for this or any related Medicare and/or insurance carrier claim. I permit a copy of this authorization to be used in place of the original, and I request payment of medical insurance benefits be made to METHOD HCS. Assignment of Benefits: In consideration of healthcare services provided to me by METHOD HCS for this and all subsequent services, I hereby assign to METHOD HCS any and all rights for benefits and claims I may have under any policy of insurance (Medicare, Medicare Supplement, Private Insurance, Major Medical etc.) and the proceeds from any claim. I permit a copy of this authorization and assignment to be used in place of the original. Such assignment hereby authorizes direct payment to METHOD HCS. I agree to transfer immediately to METHOD HCS any payment made directly to me for services by METHOD HCS on an assigned basis. Method HCS will not be held financially responsible for any denials of payment for lack of notification of any insurance coverage or eligibility requirements and/or any other reason. **Proof of Delivery-** I acknowledge receipt of the above equipment in clean and good working order I have received instructions in the safe and proper use of the equipment, including cleaning and maintenance requirements. **Rights and Responsibilities-** I have received and reviewed a copy of my Customer Bill of Rights and Customer Responsibilities. Furthermore, I agree to the terms and conditions. **Consumer Responsibilities-** Consumer is responsible to notify METHOD HCS, within ten (10) days of any changes in mailing address, insurance coverage and/or eligibility, or transport and/or relocation of any rental equipment. I understand that if payment of medical insurance benefits is paid to me I agree to transfer payments immediately to METHOD HCS. I understand if I do not forward payments to Method HCS I will be held financially responsible for all collections and legal remedies including fees. **Warranty-** Every product sold or rented by our company carries a 1-year manufacturer's warranty. METHOD HCS, will notify all Medicare beneficiaries of the warranty coverage, and we will honor all warranties under applicable law. METHOD HCS, will repair or replace, free of charge, Medicare-covered equipment that is under warranty. In addition, an owner's manual with warranty information will be provided to beneficiaries for all durable medical equipment. If no manual is included, please contact us immediately so a manual can be mailed to you. **Sales & Rentals-** Returns on sale items are acceptable if the item provided is unsuitable or inappropriate, all returns must comply with the return policy. No refunds issued if a rental item is returned earlier.

AUTHORIZATION AND ACKNOWLEDGEMENT

METHOD HCS is pleased to provide you with services and medically validated products. We are concerned with your care and want you to know how to obtain services if your product breaks or malfunctions. You may call our office number 801-800-8382, Monday through Friday 9:00 am to 4:00 pm MTN. For emergencies, please call 911. In some cases, METHOD HCS may assist you and perform the duties as a holder of medical or other information, and bill your insurance company for your medical equipment and services. If payment of medical insurance benefits is paid to you directly you agree to forward the payment(s) to Method HCS. You may contact us at any time concerning our services, complaints or requests for information regarding your equipment. If we cannot assist you, we will try to refer you to another organization. We care about your medical care needs, and we want you to remain a satisfied customer. Keep this letter for future reference, and we thank you for allowing us to serve you. Information Release: I authorize METHOD HCS to request a copy of my medical information including progress notes from my PHYSICIAN in order to determine my medical necessities for the item(s) listed below. Assignment of Benefits: I request that payment of authorized Medicare, Medicaid, or private insurance benefits be made payable to METHOD HCS or any covered services furnished to me by METHOD HCS. I authorize any holder of medical information about me to be released to the Center for Medicare and Medicaid Services and its agents, TRICARE and its agents, or to any private insurance company or information needed to determine these benefits or the benefits payable to related services. Payment Agreement: I understand that by my signature I requested that payment be made, and I authorize release of information necessary to pay the claim for covered services. In Medicare and Medicaid assigned cases, METHOD HCS agrees to accept the charge determination of the insurance carrier as the full charge for covered services; I agree to transfer immediately to METHOD HCS any payment made directly to me for services by METHOD HCS on an assigned basis. In addition, if payment is made to me, and if I do not transfer payments to Method HCS, I agree to be responsible for the full amount of the charges and all collections and legal remedies including fees. Operational Instruction Policy: I understand I will receive instruction in the proper use and care of any and all items delivered by METHOD HCS and METHOD HCS is available by phone to answer any questions I may have from time to time after receiving my items and I will be required to make written acknowledgement of receiving operational instructions at the time of delivery. HIPAA Consent: I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights regarding my protected health information. I understand that my health information can and will be used to (1) directly and indirectly conduct, plan or prescribe my treatment, and follow-up among multiple healthcare providers; (2) obtain payment from Medicare, my supplemental insurance, and other third party payers; and (3) conduct normal healthcare operations such as quality assessments and physician certifications. Return Policy: I understand any item delivered by METHOD HCS may be returned for a full refund within 7 days if the item is in re-salable condition and in the original packaging and I will be required to make written acknowledgement of receiving return policy information at the time of delivery. Complaint Procedure Policy: I understand if I have a complaint about any item delivered by METHOD HCS or any representative of METHOD HCS, I may call the owner or store manager of METHOD HCS at 801-800-8382, and I will be required to make written acknowledgement of receiving complaint procedure information at the time of delivery. Equipment Warranty Information: Every product sold or rented by METHOD HCS generally carries a 1-year manufacturer's warranty. METHOD HCS will honor all warranties under applicable law. METHOD HCS will facilitate the repair or replacement, free of charge, of Medicare-covered equipment that is under warranty. In addition, an owner's manual with warranty information will be provided to beneficiaries for all durable medical equipment. If no manual is included, please contact us immediately so that a manual can be mailed to you. However if the item is not working or functioning, as it should, upon the receipt of the equipment please notify us immediately. This warranty does not cover normal maintenance such as cleaning, adjusting, or lubrication and updating of equipment or parts thereof. This warranty shall be voided and not apply if the equipment, including any of its parts, is modified without our written authorization. THE WARRANTY STATED ABOVE (INCLUDING ITS LIMITATIONS), IS THE ONLY WARRANTY MADE BY METHOD HCS AND IS IN LIEU OF OTHER WARRANTIES, WHETHER EXPRESS OR IMPLIED, INCLUDING ANY WARRANTY OF MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE. METHOD HCS SHALL NOT BE LIABLE FOR CONSEQUENTIAL OR INCIDENTAL DAMAGES OF ANY KIND. **Home Safety: General Home Safety**: Have working smoke detectors on each level of your home; check them regularly. Keep stairs, halls, and exit areas free of clutter. Stairways and halls should be well lit. Emergency phone numbers should be posted by the phone. Store all chemicals and cleaners in areas that children cannot reach. All chemicals should be clearly labeled. **Bathroom Safety**: Do not use electrical appliances in the bathtub or shower. Use rubber mats or non-skid strips on the floor of the bathtub or shower. Keep medicines clearly labeled. Throw away prescriptions that have expired. **Fire Safety**: Have a planned fire exit route. Do not smoke when using oxygen; do not smoke in the same room oxygen is stored. Do not smoke in bed. Have fire extinguishers available in all cooking areas. Turn pot handles toward the back of the stove. When heaters are in use, make sure that the room is well ventilated. **Electrical Safety**: Plugs and sockets should fit firmly and require some force to insert and remove. Do not overload outlets or circuits. Always grasp the plug to remove it from the outlet. Never pull on the cord. Avoid using extension cords and never overload them. Check cords for fraying, bare wires, or other defects, especially at the point where the cord attaches to the equipment. Never run a cord across the sink, over a wet floor or under the rug. Disconnect equipment that sparks, stalls, blows a fuse, or gives the slightest shock. Report equipment malfunctions to **METHOD HCS**. **Emergency Preparedness**: In case of an emergency involving fire or natural disaster call your local emergency number at 911. I have been instructed and understand the warranty coverage on the product I have received.

ethodHCS
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