Southwest Medical
Pharmacy & Home Medical Equipment

_____ _____

PATIENT'S NAME ***EQUIPMENT PROVIDED***

AGREEMENT AND CONSENT

1. **Terms of Agreement and Medical Consent:** I understand by signing this agreement, I authorize provision of products or services to me by Southwest Medical Pharmacy & Home Medical Equipment. I also understand I am under the control of my attending physician and Pharmacy & Home Medical Equipment is not liable for any act or omission when following the instructions of said physician. This consent shall be valid for whatever period of time is reasonably necessary or until I revoke this consent in writing. Such a revocation of this consent shall have a prospective effect only.

2. I have received the Notice of Privacy Practices (located in the patient handbook) as required by HIPAA and the American Recovery and Reinvestment Act of 2009. I understand my rights associated with the law and under this law, have the right to pay in full for services provided to me by Pharmacy & Home Medical Equipment and request no disclosure of information to my health plan regarding the services rendered.

   (Choose one option below)
   Initial _____ I elect to allow Pharmacy & Home Medical Equipment to contact and disclose information to my health plan to obtain payment for services provided.
   Initial _____ I elect to pay in full for services rendered by Pharmacy & Home Medical Equipment and request no disclosure to my health plan regarding services rendered.

3. **Disclosure and Use of Information:** I understand that Pharmacy & Home Medical Equipment may disclose my health information to Medicare/Medicaid intermediaries, my private insurance company(ies) and/or authorized agents of external regulatory agencies for use in determining my health benefits or regulatory compliance. The Pharmacy & Home Medical Equipment Notice of Privacy Practices provides a more complete description of the uses and disclosures of my health information that Pharmacy & Home Medical Equipment may make. Except for uses and disclosures described and limited in the Pharmacy & Home Medical Equipment Notice of Privacy Practices, Pharmacy & Home Medical Equipment will use and disclose my health information only with a written authorization from me.

4. **Assignment of Insurance Benefits:** I authorize direct payment to Pharmacy & Home Medical Equipment of any insurance benefits otherwise payable to me for Pharmacy & Home Medical Equipment provided products or services. I also authorize my insurance company(ies) to furnish to an agent of Pharmacy & Home Medical Equipment any and all information pertaining to my insurance company(ies), or HCFA and its agents, any and all information pertaining to me for benefits determination. This assignment of benefits will be in effect from the date of delivery of the equipment listed below until revoked in writing.

5. **Acknowledgement of Financial Responsibility:** While there may be insurance coverage for services or products provided by Pharmacy & Home Medical Equipment to me relative to my therapy needs, I recognize all services may not be covered or reimbursement may be less than 100% of charges billed in accordance with my policy coverage. Therefore, I acknowledge financial responsibility for any balance owing on my account. I understand by providing my cell phone number or e-mail address and it becomes necessary for Pharmacy & Home Medical Equipment to contact me regarding my debt to Pharmacy & Home Medical Equipment, I may receive communication regarding my debt on my cell phone or via e-mail. This consent is also valid if Pharmacy & Home Medical Equipment enlists the services of an outside debt collector agency. I further give my consent to such communication. **Initial** _____

6. **Returned Goods Policy:** I understand that drugs and supplies dispensed to me **may not be returned** to Pharmacy & Home Medical Equipment for credit.

7. **Rental Equipment:** I understand the equipment delivered is **rental equipment only** and a copay may apply in line with my insurance coverage. Rental equipment remains the property of Pharmacy & Home Medical Equipment and must be returned when my prescription for the equipment expires.
   Initial _____

8. **Duplicate equipment:** ☐ **I have** ☐ **I have not** rented/purchased similar equipment before.
   Initial _____

By providing my signature below, I verify I understand my financial responsibility for the equipment or services provided.

The undersigned certifies he/she has read the foregoing, received a copy thereof and is the patient or is duly authorized as the patient's general agent to execute the above and accept its terms.

Patient Signature:	**Date:**
Patient's Agent (if applicable describe relationship to Patient): _____ **Patient Agent's Address** (if applicable) _____ _____	**Reason for alternate signature** (if applicable): _____ _____ _____ _____