Assignment of Benefits/Release of Medical Records

Customer Name _____ HICN/SSN_____

For Services rendered on _____

I authorize any holder of medical or other information about me to release to the billing agent of OxyMed any information for this or any related health claim. I agree to permit a copy of this authorization to payment from Medicare, Medicaid and/ or_____. Such records may be released to any agency or individual authorized to receive such information. I understand I have the right to refuse to release OxyMed records and that signing this consent constitutes a waiver of this right. I request that payment of authorized benefits be made on my behalf to OxyMed . If signed by someone other than the patient, I attest I have the authority to sign on behalf of the patient.

Acknowledgement of Training and Understanding

I/we have been instructed and understand the safe use and maintenance of the following equipment/therapy. I have also received the patient information package, and I have been informed of: patient's Rights and Responsibilities, company billing and collection policies, basic home safety and emergency preparation. I have also been informed of visit frequency, hours of service and the 24 hour on-call phone number, and understand that I should call the company with questions/problems as soon as possible.

Home Medical/Respiratory Equipment_____

[ ] Hospital Delivery [ ] Doctor Office Set Up [ ] Patient Came to Office [ ] Shipped

Is home environment suitable for prescribed service? Yes No

If unsuitable, recommended corrective action _____

I authorize the company to release or obtain records for the purpose of obtaining medical treatment.

_____	_____	_____
Patient Signature	If not patient, Signature by	Relationship to Patient
_____	_____	_____
Date	Address of Individual other than Patient	Reason unable to sign