



Durable Medical Equipment (DME) Therapy Consent Form

- 1) (Initial) I (the patient named below) hereby authorize Montage Medical (MM) and its staff to provide me with Durable Medical Equipment that has been prescribed by my physician who has explained the nature of this treatment and I have received all of the information I desire. No warrantee or guarantee has been made as to the results of this therapy and I understand that it is a long term therapy - not a cure for my diagnosed disorder.
2) (Initial) I do not knowingly have tuberculosis or any other serious respiratory or blood borne disease that has not been disclosed to my therapist at MM. I understand that this is protected health information and shall be held in the strictest confidence by all MM staff. This information is requested as a protection to our staff and other patients only.
3) (Initial) I have freely chosen MM as my provider and understand that I can select an outside contracted vendor. I have been advised as to MM's status as a contracted or non-contracted vendor with my health plan and was supplied with a list of other local vendors of durable medical equipment, their addresses and phone #'s.
4) (Initial) It is my responsibility to confirm my insurance coverage for durable medical equipment. (Customer service 1-800#s are located on the back side of most insurance cards). The insurance billing codes for these devices are CPAP (E0601) / Bi-Level (E0470). My insurance coverage is dictated by my individual contract and not by MM. My insurance may have a co-payment or a deductible that is my financial responsibility. (Please check with your insurance carrier). I understand and agree that regardless of my insurance coverage and potential reimbursement, that I am accepting full and complete financial responsibility for all charges for the procedure(s) indicated above.
5) (Initial) I hereby authorize direct payment of DME insurance benefits to MM, for services rendered by them. I have provided complete insurance and employment information, mailing address, and phone numbers to MM. I understand that any billing services provided by MM are done as a convenience to me and do not release me from financial liability for the services and equipment supplied by MM. Further it is my responsibility to notify MM of any changes in my insurance coverage or financial responsibilities that would directly impact the payment of the prescribed equipment.
6) (Initial) I understand that I will be required to confirm compliance with my therapy during the rental phase of my therapy in order for my insurance to approve the sale of the device. Most insurance carriers require an initial rental phase of 2-12 months before conversion to purchase. I understand that I will receive a customer compliance review form and I will return it to the MM office with my signature indicating my usage of the equipment and my desire to convert the rental to a final purchase.
7) (Initial) I have received a copy of MM's privacy policy (HIPAA) and understand that my medical information will only be used to provide for my medical care and documentation for payment from my insurance carrier.
8) (Initial) I understand and have been instructed on the prescribed usage of the durable medical equipment provided to me. I will take full responsibility for its use and care in my home. If I choose to discontinue its use, I will do so after advising my physician. I shall not hold MM responsible for any adverse consequences of any misuse, failure to use, or discontinuation of use of the durable medical equipment provided to me. I understand I'm still responsible for any incurred charges up to the point of the discontinuation and return of the equipment under the rental agreement.
9) (Initial) I understand that once the equipment has met purchase price and/or has been converted to sale, it cannot be returned to the MM for a credit, refund or exchange.
10) (Initial) I understand that all new PAP devices come with a 2-year manufacturer's warranty. MM is required to notify Medicare and private pay patients of warranty coverage and will honor all warranties under applicable laws. MM will replace or repair all Medicare and private pay equipment that is under warranty free of charge. In addition I have been provided with the manufactures operating manual for my usage.

I _____, understand that I have a choice in healthcare providers and accept financial responsibility for the goods and services that MM has provided me. I have received copies of all forms pertaining to the use and cleaning of this durable medical device & accessories and all questions regarding their and the terms contained in this agreement have been answered to my satisfaction.

Signature of patient (if not a minor) _____ Date _____

Signature of parent / guardian / other _____ Date _____

Relationship to patient _____