Phone (866)217-0372
Fax (866)229-0034

Assignment of Benefits and Medical Release

My signature, or a representative able to sign on my behalf, and date below authorizes and acknowledges:

- Impact Medical to provide product for my use as directed by a prescribing physician or nurse practitioner.
- I was given a choice of providers to use and chose to use Impact Medical.
- Impact Medical to direct bill Medicare, Medicaid, or any other insurance on my behalf.
- Gives permission to Impact Medical to obtain pertinent documentation from my medical records from the facility, hospital or other care provider which pertains to the reasons in which I am seeking supplies.
- I understand that the information I release to Impact Medical will be protected by Impact Medical as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- Acknowledges that I have received a copy of the Medicare Supplier Standards, HIPAA Privacy Policy, Method to file a Complaint, Policy and Procedures and Hours of Operations.
- Acknowledges that I am financially responsible for any supplies not covered by my insurance as well as any co-payments, co-insurance, and deductibles.
- Acknowledges that if I am unable to pay amount due to financial hardship that I, or someone on my behalf, contact Impact Medical to make arrangements based on my current financial situation.
- I hereby attest that I have provided all insurance coverage applicable for supplies received at this time. In the event I change insurance companies without notifying Impact Medical, I understand that the balance will be my responsibility.

Patient Name_____ Date of Birth_____

Patient Signature _____ 1st Date of Service_____

If the patient resides in a long Term Care Facility: In the event the patient is unable to sign, Medicare states that a staff member at the Long Term Care facility may sign on the patient's behalf.

Representative's Name_____

Representative's Signatur_____

Reason Patient unable to Sign_____