PRISM
HOME MEDICAL SUPPLY SPECIALISTS
A HENRY SCHEIN® COMPANY

PO Box 476 Elkin, NC 28621
P:(888)2446421 F:(800)9756321
Prism-medical.com

Patient Authorization for Services

MEDICARE PART A SERVICES

I understand that these supplies are not covered if I am utilizing my Part A benefit which includes, but is not limited to; Home Health Services, inpatient stays, or skilled nursing care provided in a skilled nursing facility (SNF). If I choose to acceptthese supplies while undergoing one of these episodes, as defined by CMS, I may be financially responsible for the cost of the supplied items.

RIGHTS AND RESPONSIBILITIES

My signature below acknowledges that I have received and understand the statement of rights and responsibilities. The patient rights and responsibilities may also be found at www.prism-medical.com.

AUTHORIZATION FOR SERVICES

I authorize Prism to provide supplies and/or services as ordered by my physician. I understand that I have the right to make decisions concerning my medical care, including the right to accept or refuse medical or surgical treatment or medical supplies.

PATIENT HEALTH INFORMATION AND SUPPLIER STANDARDS

My signature below acknowledges I received a copy of the Notice of Privacy Practices and Supplier Standards. The Notice of Privacy Practices can also be found at https://www.prism-medical.com/patients#stay-informed. The products and/or services provided to you by supplier, "PRISM" are subject to the supplier standards contained in the Federal regulations shown at 42 Code of Federal Regulations Section 424.57(c). These standards concern business professional and operational matters (e.g., honoring warranties and hours of operation). The full text of these standards can be obtained from the U.S. Government Printing Office website and wecan furnish you a written copy of the standards by request.

ASSIGNMENT OF BENEFITS

I authorize payment directly to Prism of any benefits otherwise payable to examination or treatment of client. I agree to pay any charges not covered by insurance benefit plans, excluding Medicare and Medicaid recipients and where payment is prohibited by law. Primary Insurance pays for 80%. Client is responsible for 20% of approved charges and any unpaid annual deductible. **I understand that Medicare or my primary insurance will only cover products deemed as "medically necessary" and payments made by Medicare is based on their regulations, utilization limits and fee schedules.**

EMERGENCY MANAGEMENT PLAN

My signature below acknowledges that I have established and understand the emergency plan. I have received PRISM's brochure; I am informed of the nature and procedure to request additional supplies I may need; and I have participated in the planning ofmy care. There are no home visits appropriate for the care provided. The PRISM Emergency Management Plan is located at https://www.prism-medical.com/patients#stay-informed. You may also call to request the policy via mail.

RELEASE OF INFORMATION

I certify that the information given by me in applying for payment under Title XVIII of the Social Act, or under a policy of insurance is correct. I authorize the home care company or any other holder of medical or other information about the above named client, to release or receive such information to any government agency or insurance company to whom application has been made for payment for services rendered to the above client,to any physicians, hospitals, other healthcare providers or facilities, institutions, or agencies providing treatment to the client or providing continuity of care; and to quality reviewers.

PRODUCT WARRANTY

Supplies distributed by Prism Medical Products, L.L.C. are guaranteed to be free from defect. Beneficiaries that report a defective product may return it within 14 days to be replaced or refunded, at no cost. Returns may still be completed for up to 30 days; however, the patient is responsible for coordinating the return after the initial 14 day period. Opened or unopened compression garments are accepted. Unused, sterile supplies must be returned in sealed packaging for account credit. Where applicable, additional warranty information will be provided to beneficiaries. I have been instructed and understand the warranty coverage on the product(s) I have received.

Patient Name

_____

Date of Birth

_____

Patient Telephone Number

_____

My Preferred Methods of Communication

☐ Text ☐ Phone ☐ Email

_____

Patient Email

_____

Patient or Caregiver Signature

Your privacy is important to us. Your information is stored securely and used in accordance with our privacy policy.

By providing your email or telephone number to us, you are providing prior express written consent to receive information related to services received, refill reminders, account balance details, other Prism services, marketing updates, and general communication from Prism. These communications may include emails, text messages, phone calls (including those made using an automatic dialer or prerecorded voice messages). Your consent is not a condition of purchasing any products or services and you may opt-out at any time.