PATIENT INFORMATION FORM

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PATIENT SOC. SECURITY NO. ☐☐☐–☐☐–☐☐☐☐	DATE UNIT ISSUED ☐☐☐ INJURY DATE ☐☐☐
PATIENT NAME:	TYPE OF CLAIM ❑ Worker's Comp
ADDRESS	❑ Group Health Ins. ❑ Auto
CITY STATE ZIP	BIRTH DATE (DOB) ☐☐☐ ❑ MALE ❑ FEMALE
HOME PHONE ( )	PATIENT'S RELATIONSHIP TO INSURED ❑ SELF ❑ SPOUSE ❑ CHILD ❑ OTHER
HOME E-MAIIL ADDRESS	EMERGENCY CONTACT PHONE NUMBER
PRIMARY INSURANCE	POLICY/CLAIM NO.
ADDRESS	ADJUSTER NAME
CITY STATE ZIP	GROUP NO. PHONE ( )
INSURED'S NAME DOB ☐☐☐	INSURED'S SOC. SEC. NO. ☐☐☐–☐☐–☐☐☐☐
SECONDARY INSURANCE	POLICY/CLAIM NO.
ADDRESS	ADJUSTER NAME
CITY STATE ZIP	GROUP NO. PHONE ( )
INSURED'S NAME DOB ☐☐☐	INSURED'S SOC. SEC. NO. ☐☐☐–☐☐–☐☐☐☐
EMPLOYER	WORK PHONE ( )
ADDRESS	CITY STATE ZIP
PRESCRIBING PHYSICIAN	REPRESENTATIVE
ADDRESS	REFERRAL SOURCE/CLINIC
CITY STATE ZIP	ADDRESS
PHONE ( ) FAX ( )	CITY STATE ZIP
NPI # LIC/UPIN#	PHONE ( ) FAX ( )

Notice of Privacy Practices Acknowledgement/Assignment of Benefits/Proof of Delivery

I hereby acknowledge that I have received a copy of Electrostim Medical Services, Inc. (hereafter referred to throughout this document as EMSI) Notice of Privacy Practices.

I hereby authorize payment of medical benefits to EMSI for services furnished.

I authorize the release of my medical and/or billing information to EMSI, my insurance carrier(s), third party payers and their agents, physician, attorney, employer, physical therapist, guardian (if applicable), debt collection agencies, and family. I permit a copy of this authorization to be as valid as the original.

I hereby acknowledge that EMSI bills third-party payers as a courtesy. I understand that I am financially responsible for all deductibles, coinsurance and denied services.

I hereby acknowledge that I have read and understood all terms and conditions outlined on the back of this document.

Patient Name (Print) _____ Patient/Guardian Signature _____

Date _____

Rights, Responsibilities, Rental & Sales Agreement

Company when used in this agreement refers to Electrostim Medical Services, Inc.. hereafter referred to throughout this document as EMSI, Patient refers to the person receiving medical devices. TITLE to the rental equipment & all parts shall remain with the Company, unless equipment is purchased & paid for in full. Patient must promptly notify Company of rental equipment malfunctions or defects & allow Company of rental equipment, including that caused by use or improper functioning of equipment, the act or omission of any third party, or by any criminal act or activity, fire or act of God. Company may impose a monthly service charge of 1-1/2% of the unpaid balance. Sales Returns may be accepted if the outer package (the shipping envelope) is unopened and in salable condition and is returned within 60 days from the Date of Service. Patients will need to call and notify us that they are returning items OR the return package would need to be postage stamped within the 60 day window. No merchandise may be accepted for return if worn next to the skin, used for sanitary or hygienic purposes or if it is disposable (supplies, creams, etc.) Special order items will require a deposit & are non-returnable. Should a life threatening MEDICAL EMERGENCY arise at is suggested the patient or caregiver contact their local emergency services number for assistance. Patient will be communicated with in a way they can understand. Those wishing to express their concerns or comments or review, restrict or revoke consent on their files, should contact the Company during regular business hours. Your COMMENTS will be reviewed & acted upon. Ongoing concerns should be directed to your state department of health. Patient retains the right to refuse Company services & assumes responsibility for any consequence relating to REFUSAL of any service ordered delivered to the patient by a health care professional Patient may participate in all decisions regarding service, including admission, plan of service, discharge, transfer & referral and will receive experimental treatment only with a voluntary informed consent. Patient personal health care information listed will be kept CONFIDENTIAL by Company and only used for health care operations, services & payment purposes (A complete copy of this policy is available for review in our office). In the interest of health & safety, Company retains the RIGHT TO REFUSE DELIVERY of service at any time, however, does not discriminate. Patient has a right to respect, dignity, privacy, choice, informed consent, special communication needs, participation in the care planning process, adequate care & services, description & charges of those services available and payment for them. Patient agrees to notify Company of any MEDICAL STATUS change such as doctors's prescription, advance directives being in place of changed, acquiring an infection requiring hospitalization or MD visit, change of residence or insurance coverage. Company maintains appropriate liability coverage on employee theft or injury while providing services. Staff always wear name tags for identification. Patient and Company agree to go to arbitration if a disagreement arises between the parties, Medicare Hotline # 800-633-4227
It is the patient's responsibility to contact EMSI in order to stop the mailing of any additional supplies and/or the return of the unit if is is no longer needed.

MISSION STATEMENT: We constantly strive to exceed our customer's expectations in providing the greatest selection & value in home health care products & services to assist in improving their quality of life.

AUTHORIZATION TO ASSIGN BENEFITS TO PROVIDER, WAIVER, ACKNOWLEDGEMENT OF INSTRUCTIONS & RETURN DEMONSTRATION

I am under the care of my physician who has determined that _____ is an effective modality for my diagnosis, which is the result of an accident /illness. I authorize EMSI to supply said equipment. I understand that this equipment is to be used only for my diagnosed problem and issued under the order of a licensed physician. I authorize EMSI to provide me with the required electrical stimulation supplies for the unit on a monthly/quarterly basis, depending on the unit prescribed and billing guidelines set forth by the payer. I understand that EMSI functions as a supplier and that my physician took extra time to supply the modality prescribed herein and authorize for this service.

I request that payment of authorized third-party benefits be made on my behalf to EMSI for products & services that they have provided me. I further authorize a copy of this agreement to be used in place of the original & authorize any holder of medical information about me to release said medical information to EMSI or to third-party payers and their agents, any information needed to determine these benefits or compliance with current health care standards. EMSI bills third party-payers as a courtesy; I understand that I am fully responsible for all deductibles, coinsurance & disallowables. Also, I understand that third parties will only pay for services that they determine "reasonable and necessary". If determined that a particular item of service, although if would otherwise be covered, is "not reasonable and necessary third-parties may deny payment. I authorize my attorney(s) to provide EMSI with a letter of protection for my claims and to pay immediately from a favorable settlement all EMSI claims.

Additionally. I acknowledge receiving instructions, warnings & precautions, demonstrated or verbalized my understanding in the proper use & care of the equipment or supplies received today & will follow them. I understand company business hours & after-hours service policy & have had my financial responsibilities regarding this agreement explained, understand & will abide by them. I certify that all information appearing on this document is correct.

ASSIGNMENT OF BENEFITS

Pursuant to Florida Statute 627.736(5) the undersigned patient hereby assigns the benefits of insurance and any and all causes of action under the policy of. _____ _____, my automobile insurance company to EMSI to receive payment for equipment and services rendered to the undersigned and which are payable under Personal Injury Protection Coverage (PIP) and/or Medical Payments Coverage of my auto insurance policy.

As prescribed by Florida Statute 627.730_627.741, all payments shall be overdue if not paid within 30 days after the insurer is furnished written notice of the fact of a covered loss and the amount of same. All overdue payments shall bear simple interest at the rate prescribed by statute.

By virtue of this assignment, the undersigned directs that all payments should be issued solely in the provider's name and forwarded directly to the office of Electrostim Medical Services, Inc.
In the event of a dispute involving payment of my physician's bill, in order to maximize the benefits available under by policy coverage, and to continue to receive necessary treatment while the dispute is being resolved, I request the company adhere to the following. Assuming there is coverage remaining at the time the Company receives the physicians's bill, if the company fails to pay Electrostim Medical Services, Inc. the full amount of the treatment bill submitted, to avoid the exhaustion of coverage while this provider pursues its rights under this Assignment, I authorize and direct the Insurance Company, to set aside and place in escrow, an amount equal to the full amount of any such reduction/non-payment and to hold that amount in escrow until the dispute is resolved in the appropriate forum.

Further, I authorize and direct my insurance Company to provide Electrostim Medical Services, Inc. and/or their Attorney, a complete, unaltered copy of the PIP and Medical Payments coverage payment records as needed to include all provides, payments, dates received and amounts paid.

To the extent that any provision of this assignment is found to be unenforceable, all remaining provisions shall remain in full force and effect. A photocopy of this Assignment shall be considered as effective as the original.