Tactile™ MEDICAL

PATIENT CONSENT

CONSENT FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I understand that Tactile Medical (Tactile) originates, collects and maintains paper and/or electronic records describing my Protected Health Information (PHI) such as health history, diagnosis, symptoms, test results, etc. I consent to the use and disclosure of my PHI by Tactile, its staff, and its business associates for treatment, payment and health care operations.

I understand I have a right to request restrictions or revoke any use and/or disclosure of my PHI by Tactile. A detailed description of my rights was provided to me in the Notice of Privacy Practices. This authorization is effective for 5 years unless otherwise provided by law.

I consent to the release of PHI by Tactile to my health care providers and insurance company(ies). I authorize and consent to the release by my health care providers to Tactile and any insurance company(ies), all PHI necessary to secure payment.

I understand Tactile may desire to review de-identified health information for the purposes of clinical research, evaluation of patient outcomes, or clinical protocol development. I consent to the release and use of my de-identified information so long as Tactile ensures that I cannot be identified through release and use of that information.

ASSIGNMENT OF BENEFITS

I assign payment of medical benefits to Tactile and direct any payer to make payment on my behalf directly to Tactile. I understand that all costs not covered by my insurance are my responsibility. I understand that in the event my insurance company makes payment directly to me for the medical equipment provided by Tactile, I am responsible for ensuring payment in full is made promptly to Tactile.

CONSENT TO LEAVE MESSAGES

☐ I authorize Tactile to leave voice mail messages for me regarding medical and/or billing information at the following number(s):

(_____) _____ ☐ Day ☐ Evening (_____) _____ ☐ Day ☐ Evening

☐ I authorize Tactile to leave messages with or respond to inquiries from the following individual(s):

NAME | RELATIONSHIP | PHONE

NAME | RELATIONSHIP | PHONE

☐ I do not authorize Tactile to leave voice mail messages containing medical or billing information.

CONSENT TO EMAIL

☐ I grant permission to use the email address provided for the sole purpose of communicating with me regarding my Tactile order. I understand that in order to secure my electronic PHI, email messages from Tactile may be encrypted. Encrypted email will require that I click on a provided link and create a password in order to view the secure email.

EMAIL ADDRESS

PATIENT SIGNATURE

By signing this, I agree to all the terms and conditions listed above.

PATIENT NAME (PLEASE PRINT) | PATIENT SIGNATURE | DATE

GUARDIAN NAME (IF APPLICABLE, PLEASE PRINT) | GUARDIAN SIGNATURE | DATE

Please return completed form to Tactile Medical. **Mail:** 1331 Tyler Street NE, Suite 200, Minneapolis, MN 55413 **Fax:** 866.435.3949

To speak with a Patient Services representative, call toll-free: 866.435.3948

Tactile Medical
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Hours: Monday through Friday, 8 a.m. – 5 p.m. CT
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