ASSIGNMENT OF BENEFITS / CONSENT FOR SERVICES

Provider # 0215100001, 0215100002, 0215100003, 0215100004, 0215100005

Patient Name: _____ Acct #: _____

Equipment: _____

Request for Medical Services
I understand that by signing this agreement, I authorize provision of products or services or both from AHM or its affiliates.

Medical Supervision and Responsibility
I understand that I am under the care and supervision of my attending physician. The nature and purpose of the medical products, supplies and/or services and the risks or possibility of complications have been fully explained to me by my physician.

Agreement to Pay
In consideration for AHM providing medical products, supplies and/or services as ordered by the patient and/or physician, I the undersigned agree that the responsibility for payment for any such products and services rests with me.

Assignment Agreement
I request that payment of authorized Medicare, Medicaid or other insurance be made on my behalf directly to AHM any medical products, supplies or services rendered by AHM. In the event payments of insurance benefits are made directly to me, the payee will endorse to AHME all checks for such payments.

Release of Information
I hereby authorize any holder of medical information about me to release to my insurance carrier or any agency or representative of said insurance company for the purpose of obtaining payment for services provided to me. I also authorize the review of my records including medical records by any Federal, state or accrediting body or agency as required by the regulatory, licensing or accrediting body.

Consent for Services
My physician has advised me of my need for healthcare equipment, respiratory therapy and/or supplies. By signing, I indicate my wish to rent or purchase healthcare equipment and/or supplies and receive related services from Alick's Home Medical Equipment, Inc. (Alick's). I understand that Alick's did not prescribe this equipment, supply or related service and cannot guarantee its success in treating any particular condition. I also understand my physician is solely responsible for diagnosing my condition, for prescribing medication or other treatments, and for supervising my care. I understand there are benefits and risks known, and unknown associated with this home medical equipment, supply or therapy and that my physician, nurse or pharmacist has explained this to me. My care will be under the supervision of my licensed physician.

I the undersigned certify that I have read the foregoing and received a copy of this document. I also certify that I am the patient or am authorized by the patient as the patient's general agent to execute the above and accept its terms. I understand that no modifications of this contract will be binding unless such modifications are in writing, duly accepted, and executed by both parties. A duplicate copy of this Agreement shall be considered the same as an original.

Patient/Responsible Party – signature	Patient/Responsible Party – please print	Date

Responsible Party's Relationship to Patient