ADVANCED RECOVERY SPECIALISTS

Patient Agreement

Date of Delivery: _____

PATIENT INFORMATION: *(hereinafter "Patient")*

Name: _____ Mobile: _____

Street Address: _____ Home/Work Phone: _____

City: _____ State: _____ Zip: _____ SSN: _____

DOB (MM/DD/YYYY): _____ Email Address: _____

ALTERNATIVE CONTACT:

Name: _____ Mobile: _____

Email: _____ Relationship: _____

UNIT SERIAL NUMBER: _____

☐ CCT ☐ DVT ☐ REHAB SLED

☐ ONLUX ☐ OTHER _____

DELIVERED BY: _____

WRAPS: _____

INSURANCE TYPE:

☐ Personal Injury ☐ Workers' Compensation ☐ VA ☐ TRICARE ☐ Other _____

PRODUCT DELIVERY COMPLETED (PLEASE SIGN): _____

PATIENT EDUCATION COMPLETED (PLEASE SIGN): _____

Agreement: I, the undersigned Patient, certify that all information I have provided is true and correct. I have been informed of my treatment options, rights, responsibilities, and the complaint procedures to follow if I have any issues with the treatment plan. I have been instructed on the safe and proper use of the equipment and/or accessories and/or supplies provided ("Medical Device"). I understand that this Medical Device has been provided for my use on the orders of my health care provider based on the determination that it is medically necessary. I agree to notify Advanced Recovery Solutions ("ARS") immediately when my health care provider determines that I no longer need to use the Medical Device. I understand that the Medical Device is owned by ARS and is rented by ARS to me for my use pursuant to this Agreement. I accept financial responsibility for the Medical Device. I will return the Medical Device, promptly at the end of the rental period, to ARS in the same condition in which I received it. I agree to protect, indemnify and hold harmless ARS, its owners, employees and agents against all claims, damages, costs (including legal expenses), arising out of my use of the equipment or out of my decision not to use the Medical Device. I authorize ARS to bill any applicable third-party payors and hereby assign my benefits to ARS. I authorize ARS to release and to request and receive medical information about me, to and from third-party payors, insurance companies, utilization review organizations, and etc. in accordance with the HIPAA of 1996, as amended. I have read the terms and conditions of this Agreement and agree to be bound by its provisions. To the extent I am not able to provide legal consent, a legal representative is signing this Agreement on my behalf.

PATIENT SIGNATURE: _____ DATE: _____

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