PATIENT AGREEMENT / AOB / XB

Account Number: _____

Patient Name: _____ Date of Birth: _____

REQUEST FOR PROVISION OF SERVICES

I understand that by signing this agreement, I indicate my wish to purchase health care products or services or both from Maryland Real Life Designs, LLC (MRLD).

INDICATION OF MEDICAL RESPONSIBILITY

I understand that I am under the supervision and control of my attending physician. I also understand that my physician has prescribed the therapy noted as part of my treatment. I understand that the services of MRLD do not include diagnostic, prescriptive, or other functions typically performed by licensed physicians, and that my physician is solely responsible for diagnosing and prescribing drugs and/or therapy for my condition and otherwise supervising and controlling my medical care. I agree to notify MRLD of any changes insurance coverage or status.

AGREEMENT TO PAY

In consideration of MRLD undertaking to supply patient with any products and services ordered by patient or behalf of patient. The undersigned patient, spouse, guarantor and/or guardian agree that each of them is responsible for payment to MRLD for all such products and services provided patient. In addition, I agree to pay the balance due in full upon receipt of an invoice, unless prior written arrangements have been made. If payment is not made, I/we understand that MRLD will follow its normal collection policy. I also agree to pay all collection fees, attorney fees, and court costs if MRLD has followed through with any collection procedures.

RELEASE OF INFORMATION

To undersigned authorize our insurer(s) and any third-party payer who provides patient with coverage to disclose to MRLD any information regarding such coverage, including but not limited to A) payments made by such insurer(s) or third-party payers(s) to any of us; B) the scope and extent of coverage available from time to time, and allow MRLD to release patient information. Patient authorizes all medical personnel to provide information to MRLD concerning his/her medical history, as it may relate to patient's home therapy.

CREDIT CHECK AUTHORIZATION AND CREDIT TERMS

MRLD is authorized to verify any information I have disclosed and perform a credit investigation for the purpose of extending credit for the purchase of orthotic/prosthetic supplies. In addition, they may answer any questions from creditors about my credit and account experiencing with MRLD.

ASSIGNMENT OF BENEFITS

The undersigned hereby authorize MRLD to request on my behalf and to collect directly all public and private insurance coverage benefits due to products and services supplied patient by MRLD. In the event that payments for insurance benefits are made directly to any of the undersigned, the payee will endorse to MRLD all checks for such payments. Responsibility for overpayments accepted per statement.

HICN _____

EXTENDED MEDICARE ASSIGNMENT

I certify that the information given by me for payment under Medicare (Title XVIII of the Social Security Act) and/or any other medical insurance is correct.

1. The patient, if physically and mentally competent, must sign on his/her behalf. If cannot sign for himself/herself, a representative payee as designed by the Social Security Administration, or a legally appointed guardian may sign: the source of the signatory's authority should be stated. (*E.g., Social Security appointed Representative Payee, court appointed guardian, etc.*)
2. This form is issued in lieu of the patient's signature on the request for payment HCFA-1500 (1-84) and is, therefore an extension of that form. Anyone who misrepresents or falsifies essential information in making Medicare claims may, upon conviction, be subjected to fine and imprisonment under Federal Law. Furthermore, in signing, the beneficiary authorizes any holder of medical or other information about himself/herself to release to Social Security Administration or its intermediaries or carrier any information needed to process related Medicare claims. He/She further permits a copy of the authorization to be used in place of this original.
3. On assigned claims, the provider agrees to accept the Medicare Carriers allowable amount as the full charge for coverage services; the patient is responsible for the deductible, co-insurance, and non-covered services. This authorization may be cancelled by mutual agreement of the provider and customer at any time by written notice to the Medicare Carrier.

I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished me by or in MRLD, including physician services. I authorize any holder of medical or other information about me to release to the Center of Medicare and Medicaid Services and its agents any information needed to determine these benefits for related services.

For Medicare Patients Only ☐ **I certify that I have received a copy of the Medicare Suppliers Standards**

The undersigned certifies that he/she has read the foregoing and certifies that he/she is the patient or is duly authorized by the patient as patient's general agent to execute the above and accepted its terms.

Note: A duplicate copy of this Agreement and Consent shall be considered the same as an original.

_____

Patient/Spouse/Guarantor/Guardian/Signature **Relationship to Patient** **Date**