

# NEW ENGLAND MEDICAL SOLUTIONS

PO BOX 10232, BEDOFRD, NH 03110  
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## Patient Rental Agreement and Proof of Delivery

Date of Service \_\_\_\_\_ Patient's Name \_\_\_\_\_ DOB (MM/DD/YYYY) \_\_\_\_\_  
Delivery Address: \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Product Description: \_\_\_\_\_  
Start Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Stop Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

SERIAL NUMBER: \_\_\_\_\_

Patient Product Education Patient Bill of Rights and Responsibilities: By signing below I acknowledge, authorize, and understand that NEW ENGLAND MEDICAL SOLUTIONS is the provider of the medical products I am receiving today which are prescribed by my physician. I authorize NEW ENGLAND MEDICAL SOLUTIONS and its Business Partners to deliver, teach, administer or perform, as necessary, the product and treatment prescribed by my physician. I have been instructed in the proper fitting and usage of the product(s) received. I understand that once the equipment has been used it is no longer able to be returned (unless rental item), refunded or re-sized. I have been instructed to contact my physician for any questions or concerns related to my medical care or status. Warranty: we will honor all warranties honored by the manufacturer of the product. If the product becomes defective, it is your responsibility to notify NEW ENGLAND MEDICAL SOLUTIONS immediately and its Business Partners to resolve the situation in a timely manner. Failure to notify will lead to missed treatments prescribed by your physician. (You Must Call NEW ENGLAND MEDICAL SOLUTIONS). I acknowledge that I have been given the patient manual, product warranty, package, and instructions on how to contact NEW ENGLAND MEDICAL SOLUTIONS. I have also received a copy of the Notice of Privacy Practices.

Assignment of Benefit (AOB), Release of Information, Estimated Patient Responsibility: By Signing below, I authorize NEW ENGLAND MEDICAL SOLUTIONS or its Business Partners to submit a claim for such product(s) to my insurer on my behalf and assign the benefits payable to my insurer for such products. I authorize my health Care Provider and NEW ENGLAND MEDICAL SOLUTIONS to release medical Information required by my insurer or attorney to process the claim. I understand that any patient responsibility amount provided to me by NEW ENGLAND MEDICAL SOLUTIONS or their representative is an ESTIMATE only. If I have more coverage than written above, it is my responsibility to notify NEW ENGLAND MEDICAL SOLUTIONS. I understand that there is no guarantee of payment by my insurer and that regardless of insurance coverage I am ultimately responsible for my bill. I further understand that the pre-authorization process is a courtesy by NEW ENGLAND MEDICAL SOLUTIONS and its Business Partners, and it is my responsibility to contact my insurer if I have questions about my potential financial obligations for the product. I certify by signing below that I prefer the product(s) I am receiving/ordered are prescribed by my physician and will be billed to my insurance by NEW ENGLAND MEDICAL SOLUTIONS. I request payment of authorized insurance benefits for related services to the supplier. I acknowledge and understand by signing below that I am responsible for all charges for products received by me. Although I am requesting NEW ENGLAND MEDICAL SOLUTIONS and its Business Partners to bill my insurance company on my behalf, I understand that it is still my responsibility to ensure the claim is paid in a reasonable time. I agree to provide a credit card number for billing, if applicable, for any reason any portion of my bill is not paid by my insurance, I further agree to make arrangements for my prompt payment of the bill. (You will receive a separate statement for any co-insurance, deductible or non-covered Items.) ***A Workers' Comp patient is never responsible for a bill.***

\_\_\_\_\_  
Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

If signature is other than patient, please complete the following:

\_\_\_\_\_  
Printed Name of Person Signing Above \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ Area Code/Telephone \_\_\_\_\_