ORTHOPEDICS NEW ENGLAND

313 SPEEN ST, NATICK, MA 01760
PHONE: 603-703-4789 FAX: 603-676-0000

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 ORTHOEDICS NEW ENGLAND is the provider of the medical products I am receiving today which are prescribed by my physician. I authorize ORTHOEDICS NEW ENGLAND 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 ORTHOEDICS NEW ENGLAND 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 ORTHOEDICS NEW ENGLAND). I acknowledge that I have been given the patient manual, product warranty, package, and instructions on how to contact ORTHOEDICS NEW ENGLAND. 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 ORTHOEDICS NEW ENGLAND 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 ORTHOEDICS NEW ENGLAND 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 ORTHOEDICS NEW ENGLAND or their representative is an ESTIMATE only. If I have more coverage than written above, it is my responsibility to notify ORTHOEDICS NEW ENGLAND. 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 ORTHOEDICS NEW ENGLAND 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 ORTHOEDICS NEW ENGLAND. 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 ORTHOEDICS NEW ENGLAND 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

ORIGINAL - ORTHOEDICS NEW ENGLAND COPY - PATIENT