North American Spine & Pain Clinic

DME Delivery Receipt

Product Dispensed - Signature Form

Patient Information			
Patient Name (Last, First, Middle) Pancrazio Angela	**Patient ID** P100026	**Patient DOB** 02/01/1985	**Primary Device Type** Orthopedics

Product / Procedure				
L-CODE	**QTY**	**DESCRIPTION**	**SIZE**	**ORIENTATION**
L1833	1	Knee orthosis (KO), adjustable knee joints (unicentric or polycentric), positional orthosis, rigid support, prefabricated, off-the shelf	No	No

PRESCRIPTION		
Projected Monthly Frequency Daily	Estimated Length of Need Lifetime	Start Date 07/22/2024
Insurance / Medicare Info Horizon BCBS	Prescriber Name James Bresnahan	Prescriber NPI 1222
Doctor Name -		Doctor NPI -
Prescriber Address NASPACS		Prescriber Work Phone +1-7887878787

AUTHORIZATION TO ASSIGN BENEFITS TO PROVIDER & RELEASE MEDICAL INFORMATION

My signature below states that I request and authorize payment from the Centers for Medicare and Medicaid Services or my Primary, Secondary or Tertiary Insurance carriers of benefits to be made on my behalf to the above company and its physicians or medical staff for medical equipment, products or services that they have provided me. I further authorize the above provider and authorized holders of my medical information to release to the Centers of Medicare and Medicaid Services and its agents or affiliates any information needed to determine these benefits or compliance with current healthcare standards. I have

received a copy of the HIPAA privacy statement. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act, or under a policy of insurance is correct. I authorized any of my medical providers or any other holder of my medical information or the above-named patient, to be released or received by any governmental agency or insurance company to whom application has been made for payment for services rendered to myself or the above patient; to any physicians, other healthcare providers or facilities, institutions or agencies providing treatment to myself or the above-named patient or providing continuity of care and to quality reviewers. The terms of the agreement are incorporated herein and part hereof, and I acknowledge that I have read the same and received a copy thereof. I authorize North American Spine and Pain to provide care and/or services. I understand that I have the right to make decisions about my medical care, including the right to accept or refuse medical or surgical treatment or equipment.

MY SIGNATURE BELOW STATES THAT I HAVE RECEIVED THE ABOVE MEDICAL EQUIPMENT ITEM(S) IN GOOD CONDITION AND IN PROPER WORKING ORDER. I HAVE BEEN PROPERLY TRAINED AND INSTRUCTED ON THE USE AND CARE OF THE MEDICAL EQUIPMENT(S) AND THE MANUFACTURE GUIDELINES, PRODUCT SAFETY (HOME SAFETY ASSESSMENT), MAINTENANCE AND CLEANING AND WARRANTIES. I UNDERSTAND AND HAVE READ MY RIGHTS AND RESPONSIBILITIES ALONG WITH REPAIR AND REFUND POLICIES, MY SIGNATURE BELOW ALSO STATES THAT THE ITEM(S) DISPENSED TO ME HAVE BEEN INSPECTED FOR STRUCTURAL SAFETY AND MEET THE SPECIFICATIONS OF MY CURRENT PRESCRIPTION/WRITTEN DOCTOR'S ORDER. I HAVE READ AND AGREE TO EACH AND ALL OF THE TERMS AND CONDITIONS WRITTEN IN THIS DOCUMENT. I CONSENT TO RECEIVE MEDICAL EQUIPMENT AND SERVICES FROM THE ABOVE-NAMED PROVIDER

PATIENT SIGNATURE

DATE: 07-25-2024