F: 312.896.1436

Delivery Date _____

PATIENT DELIVERY TICKET

PATIENT INFORMATION:

Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Emergency Contact Name: _____ Phone #: _____

Equipment Rental Start Date: _____ Equipment Rental End Date: _____

Self-Pay Amount (if applicable): $ _____

EQUIPMENT:

	DEVICE NUMBER	DEVICE STICKER
Continuous Passive Motion (CPM Device):		
Thermal Compression Therapy Device:		
Sequential Compression Therapy Device:		
Orthopedic Bracing:		
Mobilization Sling:		
Other:		

PATIENT ORIENTATION CHECKLIST – DIRECT TO PATIENT FULFILLMENT:

SAFE AND APPROPRIATE USE OF EQUIPMENT

Patient confirmed a clear understanding of health care practitioner's prescribed use of equipment.	YES / NO
Patient received information on warnings and contraindications associated with use of System.	YES / NO
Patient trained on/demonstrated safe operation of:	
Safe placement of unit in residence and grounded outlet power connection for equipment;	YES / NO
Safe operation/handling of System, including electrical safety;	YES / NO
Proper care of all components of the equipment while in patient possession.	YES / NO

PATIENT RIGHTS, RESPONSIBILITIES AND DATA PRIVACY

Patient provided with a copy of:	
Patient Rental Delivery Ticket;	YES / NO
Patient Rights & Responsibilities, Patient Privacy Notice;	YES / NO
Fall Prevention Measures.	YES / NO
Patient instructed on how to contact the provider for product return, troubleshooting, etc.	YES / NO

PATIENT ACKNOWLEDGEMENT:

I hereby authorize my provider and/or any holder of medical information to release to third party payers, insurance companies, health insurers, or medical necessity/utilization review organizations, any information needed to determine payment of authorized benefits until all outstanding charges for equipment associated with provider have been paid. I understand that I am responsible to the provider for all charges not covered by my insurance. I certify that I have read the terms and conditions of this agreement and agree to be bound by such provisions. I accept full responsibility for all services rendered, including being informed of my rights, responsibilities and the complaint procedures. I acknowledge I have received a copy of Patient Rights & Responsibilities and Privacy Notices. I understand that these device(s) have been issued by prescription only and are only to be utilized as directed by my physician. My signature attests that I have received and/or been instructed, in detail, on the above information.

PATIENT SIGNATURE, PERSONAL REPRESENTATIVE or RESPONSIBLE PARTY SIGNATURE:

Patient Signature: _____ Date: _____

Is patient under the age of 18 or does the patient have a legal guardian? ☐ YES ☐ NO *If yes, please complete following:*

Authorized Representative Name (print): _____

Authorized Representative Signature: _____ Date: _____

Service Technician Signature: _____ Date: _____

PATIENT RIGHTS: You have the right to be treated with respect, consideration and dignity. You have the right to high-quality medical care delivered in a safe, timely, efficient and cost-effective manner and the right to be assured that the expected results can be reasonably anticipated. You have the right to privacy to the extent possible. You have the right to have your disclosures and records treated confidentially and, except when required by law, those disclosures and records will not be released without your approval. You have the right to be provided, to the degree known, complete information concerning your diagnosis, evaluation, treatment and prognosis. You have the right to copies of your medical records at a nominal cost and, if you request it, those records will be transferred to another practitioner in a timely manner. You have the right to be informed of all reasonable options or alternatives for care and/or treatment and of the potential advantages & disadvantages of each including the advantages & disadvantages and the alternatives to having the procedure performed in an office or other out-patient facility. You have the right to participate in decisions regarding all aspects of care. No treatment will be undertaken without your informed consent after the alternatives mentioned above have been discussed with you. You have the right to refuse any treatment and to be advised of the likely medical consequences of such refusal. You have the right to know all of your rights as outlined above. You have the right to know the conduct expected of you and the consequences of failure to comply with these expectations. You have the right to know the services available. You have the right to know the provisions for after-hours and emergency. You have the right to know if any of the planned treatment is part of a research study and the right to refuse to participate in that study. You have the right to know whether or not your providers are insured. You have the right to know how to go about expressing suggestions and the policies regarding grievance and external appeals in the event that you are dissatisfied with your treatment. You have the right to know the name of your provider. You have the right to know what fees are expected and what payment policies are. You have the right to know what your provider's credentials are. You have the right to change providers.

PATIENT RESPONSIBILITES: You have the responsibility to accurately and completely provide all clinical personnel with the health information they need. You have the responsibility to follow the directions regarding the equipment. You have the responsibility to abstain from the use of alcohol as directed by your physician. You have the responsibility to inform the tech or physician if you do not understand any directions or do not understand the course of treatment planned for you. You have the responsibility to timely pay all medical bills which are not in dispute and to forward to us any monies you receive from any insurance company for our services.

NOTICES OF PRIVACY PRACTICES: We maintain paper and electronic files that may contain private information about the patient and may include, but are not limited to, name, address, phone number, contact person, height & weight, diagnosis, prognosis, physician(s), prescriptions, plans of service & treatment, vital signs & other clinical impressions, insurance coverage(s), equipment rented & purchased from us, credit card number(s), dates of service, etc. We will release, transfer & disclose the above information to third parties to facilitate appropriate provision & review of services & billing for our clients of record. These files are legal documents & are also used for education, evaluating the performance of our organization, marketing & planning purposes. We have measures in place to protect patient health information as required by law. These measures include, but are not limited to, security precautions being in place in our buildings, vehicles, billing software, transactions with government entities, vendors, consultants, surveyors, your family or appointed representative & other appropriate parties, transmission of data to third-parties, telephonic & wireless communications, maintenance, retention and destruction of data, etc. You have the right to amend, restrict, revoke consent to release examine or obtain copies of the data that we have in your file and have released to others upon request. If you have questions concerning any of the above, please contact the company at the number shown on this form. At any time you can request a copy of our Notice of Privacy Practices.

COMPLAINT REPORTING INFORMATION: If you believe your rights have been violated, you may file a complaint with our organization by calling 312-291-9305. You may also contact the Joint Commission's Office of Quality and Patient Safety One Renaissance Boulevard, Oak Brook Terrace, IL 60181, by either calling 630-792-5070, faxing 630-792-5636 or emailing patientsafetyreport@jointcommission.org. You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION: We will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your identifiable health information may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your identifiable health information for the reasons described in the written authorization. You understand that we are unable to take back any disclosures already made by your permission and that we are required to retain records of your care.

RISK OF LOSS: The provider not be responsible for loss or damage to property, material or equipment belonging to the patient, his/her agents, employees, guests, suppliers or anyone directly or indirectly affiliated with you while said material property, or equipment, is in his/her care, custody and/or control.

RECALL NOTICE: The provider may recall any or all equipment upon five (5) business days written notice to patient.

INDEMNIFICATION: Patient agrees to protect, indemnify and hold harmless the provider, its officers, directors, employees and agents from and against all claims, damages and costs, including legal expenses, arising out of Patient's use of the rental equipment.

ACKNOWLEDGEMENT OF USE INSTRUCTIONS: Patient acknowledges that he/she has been instructed on how to use the equipment and takes full responsibility for the proper use and care of the equipment.

MAINTENANCE AND OPERATION: Patient shall not remove, alter, disfigure or cover up any numberings, letter or insignia displayed upon the equipment, and shall see that the equipment is not subjected to careless, unusually or needlessly rough usage. Patient shall maintain the rental equipment in good repair and operative condition, and return it in such condition to the provider. Ordinary wear and tear resulting from proper use thereof alone is routine and expected.

NO SUBLETTING/ASSIGNMENT: Patient shall not sublet the rental equipment and shall not assign or transfer any interest in this Agreement without the express prior written consent of the provider. The provider may assign this Agreement without notice. Subject to the foregoing, this Agreement accrues to the benefit of, and is binding upon, the heirs, successors and assigns of the parties to this Agreement.

MISCELLANEOUS: This medical device is provided to the Patient on the orders of the physician's prescription. The Patient is responsible for using the equipment for the purpose for which it was prescribed and only for whom it was prescribed. The Patient is responsible for notifying the provider immediately of (1) any address or telephone change whether permanent or temporary, (2) any changes in or loss of insurance coverage or of any changes in his/her physician, or (3) any equipment failure, defect or damage. The Patient is responsible for any incidental or consequential cost of repair caused by the delay or failure to notify the provider when equipment attention is needed. The Patient is responsible for arranging the return of the medical device in the same condition in which it was received (excluding normal wear and tear) to the provider. Any missing or damaged parts and/or entire medical device (if not returned or damaged beyond repair) will be billed to the Patient and/or his/her insurance company as applicable. The costs of individual components, repair costs, and/or the entire device will be determined by the current price list in effect at the time of discovery.