DELIVERY TICKET

Date: _____

Customer: _____ DOB: _____

Bill to:

_____

Deliver to:

_____

DELIVERY DATE		AMOUNT
QTY	TYPE	
TOTAL =		

DELIVERY TECHNICIANS: PERSONAL FALL/FIRE/HOME SAFETY ASSESSMENT COMPLETED: _____
NO PROBLEMS NOTED: _____ COMMENTS: _____

ORIENTATION/WARRANTY: I have received orientation for the services and safe operation, and maintenance of my equipment. I have also received warranty information on the services covered under warranty as well as have been advised of the rent/purchase option for these items.

CONFIRMATION OF RECIEPT: I have received, read and understand my Patient/Client Bill of Rights and Responsibilities and personal fall risk assessment checklist. If I am a Medicare Beneficiary, I have received a copy of the Medicare Supplier Standards. I have also received a copy of **Dr. _____**Privacy Notice which outlines how Protected Health Information about me may be used and disclosed and how I can access this information.

The Joint Commission encourages those having concerns or complaints about the quality of care being provided to bring those concerns or complaints first to the attention of **Dr. _____**. If your concerns are not addressed to your satisfaction, you may contact the Joint Commission's Office of Quality Monitoring to report any concerns or register a complaint by calling 1-800-994-6610 or emailing complaint@jcaho.org.
Matters concerning billing, insurance and payment disputes are not within the authority of the Joint Commission.

TERMS OF AGREEMENT AND MEDICAL TREATMENT CONSCENT: I understand that by signing this agreement, I authorize provision of products or services to me by of **Dr. _____**. I hereby give permission to **Dr. _____**and its affiliates to contact me regarding equipment and supply needs. I also understand that I am under the control of my attending physician and that **Dr. _____**are not liable for any act or omission when following the instructions of said physician.

MEDICARE CAPPED RENTAL AND INEXPENSIVE OR ROUTINELY PURCHASED ITEMS NOTIFICATION:
I received instructions and understand that Medicare defines the equipment type that I received as being either a capped rental or an inexpensive or routinely purchased item.

BLANKET SIGNATURE AUTHORIZATION: I hereby authorize the release to of **Dr. _____**to my insurer and necessary information for this or any related claim. I request the payment of authorized benefits be made on my behalf directly to **Dr. _____**. I do authorize **Dr. _____**to submit claims to any of the insurers as may be required.

I understand that I am responsible for DECUCTIBLES and CO-PAYMENT not covered by my insurance and to notify of **Dr. _____**promptly of any CHANGES IN INSURANCE or information that would otherwise affect claims processing. In addition, I agree to be responsible for full amount of the charges if my physician or I fail to provide the information necessary to submit the claim for payment. I agree to transfer to of **Dr. _____**immediately any payments made directly to me for services provided by of **Dr. _____** on an assigned basis. SHOULD MY INSURANCE PLAN DENY COVERAGE IN PART OR IN ITS ENTIRETY, I UNDERSTAND THAT I MAY BE RESPONSIBLE FOR PAYMENT.

I HAVE READ, UNDERSTAND AND HEREBY AGREE TO THE ABOVE CONDITIONS AND PAYMENT POLICIES.

THANK YOU FOR CHOOSING US. PLEASE CALL OUR CUSTOMER SERVICE/BILLING DEPARTMENT AT (631) 393-6888 WITH QUESTIONS OR RE-ORDERS.

Reason Patient Could Not Sign: _____ Physically Unable _____ Cognitively Impaired _____ Cannot be Disturbed

_____ Pending Discharge _____ Patient is a Minor Other: _____

_____	_____	_____	_____
Beneficiary (or Parent/Guardian/Representative) Signature	Relationship to Beneficiary (if Applicable)	Technician Initials	Date

THANK YOU FOR YOUR BUSINESS