

Insurance Information:

Patient Name: _____ DOB: ____/____/____

This service will be SELF PAY and will be paid at the time of delivery. _____
Signature Date

This service is due to a Work or Motor Vehicle Accident and I wish to use:
Workers Comp MV Insurance

ASSIGNMENT OF BENEFITS I hereby assign all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and any other health/medical plan, to issue payment directly to Merciful O&P for services rendered to myself and/or my dependents.

Primary Insurance Company: _____

Policy Holder : Self or Name : _____

Relationship to patient: _____ DOB: ____/____/____ SSN: ____/____/____

Employer: _____ Phone: _____

Secondary Primary Insurance Company:

Policy Holder : Self or Name : _____

Relationship to patient: _____ DOB: ____/____/____ SSN: ____/____/____

Employer: _____ Phone: _____

I do not have any other insurance, all insurance information has been provided above: _____ Or I DO: _____ (Initial)

Please initial ONE of the following options and sign/date below:

_____ I request Merciful O&P to obtain benefits and authorization before proceeding. I understand that a member of Merciful O&P will contact me via phone and email with a detailed service estimate which must be signed before proceeding with the device. I am aware that insurance companies can take up to 30 day to approve a device.

_____ I authorize Merciful O&P to proceed with my device(s). I understand Merciful requires a signed detailed order from my doctor before proceeding. Merciful O&P will obtain insurance benefits, and authorization, **however if my device(s) is not approved or a covered benefit, I acknowledge that I will be responsible for the full amount due for the device(s).** The service estimate approximates my out-of-pocket costs. I am responsible for any amount not covered by insurance. Merciful does not accept returns or refunds unless there is a manufacturing issue with the device(s). Device cannot be returned due to lack of insurance coverage.

PAYMENT AGREEMENT I agree that in the event my insurance or other third-party payor refuses to pay the purchase price of the equipment or service, that I will be responsible for those payments. If for any reason my account should become delinquent, I agree to pay for all billing charges, interest charges, collection fees, and reasonable legal fees. Collection calls may be made to any phone number (including cell phone numbers) that you have provided to us. I give permission for Merciful O&P to contact me by mail, phone, or voice mail message, to schedule, re-schedule, or remind me of appointments or to inform me of any insurance carrier information pertinent to my service or products being rendered.

RELEASE OF INFORMATION I authorize any of my medical providers to release to Merciful O&P any information including protected health information (PHI) necessary for the purpose of preauthorizing or billing services or goods received at Merciful O&P. I further authorize Merciful O&P to release medical records to my referring medical provider(s). I understand that this PHI will not be used for any other purposes other than outlined above and will be subject to all HIPPA rules and regulations concerning personal health information. I also understand this release is valid as long as I am under the care of the practitioners of Merciful O&P unless revoked by written request.

Patient/Gaurdian Signature: _____ Relation _____ Date: _____