HUDSON MEDICAL SUPPLY

35 Hudson St.
Yonkers, NY 10701
Tel (914) 327-4604
Fax (914) 327-4605

Follow-Up Call Needed

DELIVER TO: Patient (First/Last Name) **Date**

ADDRESS

CITY **STATE** **ZIP**

PHONE:

EQUIPMENT DELIVERED **Copay (if applicable): $0.00**

DESCRIPTION	SERIAL NUMBER	QTY
MAKE/MODEL:		

Assignment of Benefits

I hereby assign to Hudson Medical Supplies all benefits to which I am entitled in connection with my treatment. I request and authorize Hudson to release any insurance carrier information needed to process a claim and request that payment for services be made to Hudson Medical Supplies.

I understand that I will be responsible for any portion of the claim that is not covered by insurance, such as copayments of deductibles. I further understand that if I receive an item or service that is not covered by my insurance, I will be personally and fully responsible for payment.

My Signature and date in box below authorizes each of the following:

1: Assignment of Medicare, Medicaid, Medicare Supplemental or other insurance benefits to Hudson Medical Supplies.

2: Direct billing to Medicare, Medicaid Supplemental or other insurer(s).

3. Release of my medical information to Medicare, Medicaid, Medicare Supplemental or other insurers and their agents and assigns.

4. Hudson Medical Supplies to obtain medical or other information necessary in order to process my claim(s), including determining eligibility and seeking reimbursement for medical supplies and or medication provided.

5. Hudson Medical Supplies to contact me by telephone or mail regarding my medical supplies and or medication(s) order.

I agree to pay all amounts that are not covered by my insurer(s) including applicable co-payments and/or deductibles for which I am responsible.

I request that payment of Medicare, Medicaid, Medicare Supplemental or other insurance benefits be made on my behalf to Hudson Medical Supplies and/or any of our corporate affiliates for any medical supplies and/or medications furnished to me by Hudson Medical Supplies.

- **EQUIPMENT WARRANTY INFORMATION – Every product sold or rented by our company carries a 1-year manufacturer's warranty. Hudson Medical Supplies will notify all Medicare beneficiaries of the warranty coverage, and we will honor all warranties under applicable law. Hudson Medical will repair or replace, free of charge. Medicare-covered equipment that is under warranty. In addition, an owner's manual with warranty information will be provided to beneficiaries for all durable medical equipment where this manual is available.**
- **I have been instructed and understand the warranty coverage of this product I have received.**

_____ _____

PATIENT'S NAME **NAME (if other than patient)**

_____ _____

COMPANY REPRESENTATIVE'S SIGNATURE **COMPANY REPRESENTATIVE'S NAME**

Hudson Medical Supplies

I received my (please check one)

- ☐ Durable Medical Equipment. The DME specialist has explained to me all aspects of my DME equipment/supplies. In addition, I was properly instructed on how to use the equipment/supplies, and given a manual and guidelines on the usage.
- ☐ Orthotic/Prosthetic equipment/supplies today. The Orthotist/Prosthetist has explained to me all aspects of my orthotics/prosthesis equipment. In addition, I was instructed on the proper donning and doffing of the orthotics. I was given a "care and use" guide which includes a break-in schedule, and was also told to check my skin for irritations. I am aware that if I have any questions regarding my orthotics/prosthesis, I am encouraged to call the Orthotist/prosthesis.

Home Environment/Safety Assessment	☐ N/A – Not Delivered To Home
Discuss all appropriate factors and check if in order ☒ SAFETY Uncluttered pathways — Fire safety assessed Safe Operating Equipment — Cords & Adapters Safe Environment — Pt. understands safety issues Bathroom assessed — Safe Electrical Outlet Area Rugs — Getting In and Out of Device	**Appropriate for Home** ☒ **YES** ☐ **NO** ☐ Alert & Understands INSTRUCTIONS ☐ Return Demonstration by patient ☐ PT. Confused/ Caregiver Instructed ☐ Note any Personal/Physical Limits: ☐ Ph. Understands use of diabetic testing meter ☐ DME items was checked and in good working order

ADDITIONAL INSTRUCTION		
The following has been given and discussed to the patient/caregiver Check – ☒		
-Rights and Responsibilities	-Warranty information	-AOB Signature
-Service availability of company	-Capped Rental/Purchase Letter	-Equipment Instructions
-Privacy Notice	-Complaint Process (how reviewed/ Resolved)	-Infection Control Tips
-Medicare Supplier Standards	-Cleaning & Maintenance of equipment	
Complaint Protocol: If you are unhappy with the services provided by this company, please call 646-667-5608. We will respond within 5 calendar days. In the event your complaint is not resolved to your satisfaction you can contact our The Compliance team by calling 215-654-9110		

Patient Acknowledgement

I, the undersigned patient have received _____, through_____
(device type) (company)
and have reviewed all of the above and had the opportunity to ask questions.
I acknowledge receipt of the Hudson Medical Supplies *Notice of Privacy Practices.* I understand and agree to the Assignment of Benefits. I acknowledge receipt of equipment and/or supplies as indicated above.

_____ _____ _____
Signature of Patient or Patient's Rep Patient's Name Date

_____
Description of Representative's Authority to Act for Patient