Urological Supplies, Inc.
9841 Bernwood Place Dr. Ste 130
Fort Myers, FL 33966
239-985-9327, F 239-985-9614
www.urologicalsuppliesinc.com

Assignment of Benefits (AOB)

My signature and date authorizes each of the following:

1. Assignment of Medicare, Medicaid, Medicare Supplemental or other insurance benefits to Urological Supplies, Inc. for medical supplies furnished to me by Urological Supplies, Inc.
2. Direct billing to Medicare, Medicaid, Medicare Supplemental or other insurer(s).
3. Release of my medial information to Medicare, Medicaid, Medicare Supplemental or other insurers and their agents and assigns.
4. Urological Supplies, Inc. to obtain medical or other information necessary in order to process my claim(s), including eligibility and seeking reimbursement for medical supplies and/or medication(s) provided.
5. Urological Supplies, Inc. to contact me by telephone or mail regarding my medical supplies and/or medication(s) order.
6. 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.

The following Information has been provided:

1. Medicare Supplier Standards
2. Notice of Privacy Practices
3. Rights and Responsibilities
4. Hours of Operation
5. Suggestions or Complaint Procedures
6. Warranty for Products
7. Instructions for Use
8. Assignment of Benefits

I have read, received/or been instructed in detail on the items checked above.

Patient Name:_____ ID#:_____

Patient Signature:_____ Date:_____

****If patient unable to sign: authorized person*

Signature:_____ Date:_____

Address:_____Phone: _____

Company Representative Signature:_____Date:_____

Patient Acknowledgement
Receipt of Privacy Notice

I, _____ hereby affirm that I have
Patient Name
received a copy of the *Notice of Privacy Practices* from **Urological Supplies**, **Inc.**, Under federal law 104-191, also known as HIPAA,, effective March 26, 2013.
Iam entitled to receive a copy of this *Notice* from my healthcare provider.

Iunderstand that my signature on this Acknowledgement only signifies that I have received a copy of the *Notice*, and does not legally bind or obligate me in any way.

Iunderstand that I am entitled to receive a copy of the *Notice of Privacy Practices* from my healthcare provider, whether I sign this Acknowledgement or not.

Patient Name: _____

_____
Signature of Patient or Personal Representative

_____ Name
of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority (if applicable)

▼▼▼ FOR **OFFICE USE ONLY** ▼▼▼

Received by:	
Date Received:	Time Received:
Patient Declined ☐	
Staff Signature:	

Corporate Headquaters
9841 Bernwood Place Dr. ▪ Suite 130 ▪ Fort Myers ▪ Florida▪33966 ▪ Telephone 239-985-9327 ▪ Fax 239-985-9614

Urological Supplies, Inc.

Medicare Capped Rental Notification

For Capped Rental Items:

1. Medicare will pay a monthly rental fee for a period not to exceed 13 months, after which ownership of the equipment is transferred to the Medicare beneficiary.
2. After the ownership of the equipment is transferred to the Medicare beneficiary, it is the beneficiary's responsibility to arrange for any equipment service or repair.
3. Medicare considers the useful lifetime of your equipment to be 5 years or more.

Beneficiary's Name: _____

Beneficiary's Signature: _____

Date:_____

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PureWick™ Device Rental & Financial Responsibility Agreement

I understand and acknowledge the following regarding my PureWick™ device and supply rental through Urological Supplies, Inc. (USI):

1. Out-of-Network Provider
I understand that USI is considered an out-of-network provider with many insurance plans. Coverage and payment amounts are determined by my insurance company and are not guaranteed by USI.

2. Insurance Payment & Patient Responsibility
I understand that if my insurance company does not pay the full Medicare allowable amount, I agree to be financially responsible for any remaining balance, regardless of any verbal or written information provided by my insurance company regarding benefits or coverage.

3. No LCD / Experimental Coverage Acknowledgment
I understand that there is currently no Local Coverage Determination (LCD) specifically guaranteeing coverage for the PureWick™ system under certain insurance plans. Because of this, insurance companies may consider the device and/or supplies investigational, experimental, non-covered, or not medically necessary. I understand that insurance payments are subject to review and possible recoupment by the insurance company. If my insurance company requests a refund or recoups payment previously made to USI, I authorize USI to charge the credit card on file for any balance due related to my PureWick™ equipment, supplies, or rental.

4. 13-Month Rental Agreement
I understand that the PureWick™ suction machine is billed as a 13-month capped rental under Medicare guidelines. If I choose to stop using the machine before the completion of the 13-month rental period, I understand that I may still be financially responsible for the remaining rental balance owed on the equipment.

5. Monthly Wick Refill Requirement
I understand that while renting the machine, monthly wick refills must be ordered and filled every 30 days for insurance billing requirements to be met. If wick refills are not filled as required, I understand that insurance may deny payment and I may become financially responsible for the machine rental fee in full.

6. Credit Card Authorization
I authorize USI to securely keep my credit card on file and process authorized charges related to my PureWick™ orders, supplies, equipment rental agreement, insurance recoupments, denied claims, copays, coinsurance, deductibles, and outstanding balances. I understand this authorization will remain in effect until revoked in writing and all outstanding balances are paid in full.

7. Acknowledgment
By signing below, I acknowledge that I have read, understand, and agree to the terms listed above. I understand that I may contact USI with any questions regarding this agreement.

Patient/Responsible Party Signature: _____

Printed Name: _____ **Date:** _____

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Credit Card Authorization Agreement

I understand that a valid credit card must be kept on file with Urological Supplies, Inc. (USI).

I authorize USI to automatically charge my credit card for:

- Any copays, coinsurance, deductibles, or patient responsibility amounts Any
- balances not paid by my insurance company
- Any remaining rental balance owed

  Any non-covered supplies or equipment charges

I understand that charges may be processed automatically when my order is placed or when insurance processing is completed by signing below, I acknowledge that I have read, understand, and agree to the terms listed above. I understand that I may contact Urological Supplies, Inc. with any questions regarding this agreement.

Credit Card Authorization

Cardholder Name: _____

Card Type: □ Visa □ MasterCard □ Discover □ American Express

Credit Card Number: _____

Expiration Date: _____

CVV: _____

I authorize Urological Supplies, Inc. (USI) to keep my credit card securely on file and process authorized charges related to my PureWick™ orders and equipment rental agreement.

I understand this authorization will remain in effect until revoked in writing and any outstanding balances are paid in full.

Patient/Responsible Party Signature: _____

Printed Name: _____

Date: _____

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