Rehabilitation & Stimulation Medical Systems, Inc.
85 Kinderkamack Road, Suite 101
Emerson, NJ 07630
To order, please call (201) 750-0033 or (800) 822-STIM (7846)

## PATIENT CONSENT

Account #: _____

Patient's Name: _____

Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip: _____

## STATEMENT TO PERMIT PAYMENT OF INSURANCEBENEFITS TO PROVIDER, PHYSICIAN, AND PATIENT

I request that payment of authorized Medicare and/or private insurance benefits be made either to me or on my behalf to Rehabilitation & Stimulation Medical Systems, Inc. (RAS) for any services furnished to me by RAS Medical. I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services and/or my private insurance, and its agents, any information needed to determine these benefits for related services.

I understand that RAS reserves the right to review all agreements on an individual basis to determine the continued acceptance of assignment for Medicare and/or any other medical insurance companies. In the event medical necessity no longer exists or my payer no longer deems my supplies to be covered, I understand I must return the unopened, reusable supplies to RAS so they may refund my insurance. I agree to call before returning the supplies.

I acknowledge receipt and understanding of my Patient/Client Bill of Rights, Medicare DMEPOS Supplier Standards, and Notice of Privacy Practices that I received as part of my supply order and understand that I may also view a copy of these documents at www.rasmedical.com. I also acknowledge that I have received and/or will receive training on the use of all products I order from RAS. In addition, I agree that RAS may contact me in the future, via telephone, email, instant messaging, mail or other means of communication, regarding ordering medical supplies.

_____ _____
Patient's Signature Date

Note: If the patient is physically or mentally unable to sign, a representative may sign on the patient's behalf. In addition, the representative's signature, date signed, representative's name (print), address, relationship to the patient and reason why the patient cannot sign must be listed below.

_____ _____ _____
Representative's Signature Date Representative's Name (Print)

_____ _____
Representative's Address Relationship to Patient

Reason Patient Cannot Sign

_____

Please mail this completed form, not a copy, within 5 days of receipt to the address above or fax to 201-750-0033.