



PATIENT ACKNOWLEDGEMENT OF DOCUMENTATION RECEIPT

I, the undersigned, acknowledge that I have *received, read and understand* the following documents provided to me from Charm Medical Supply:

- DMEPOS Medicare Supplier Standards
- Patient's Rights and Responsibilities *
- Patient Complaint/Grievances Policy
- Patient Agreement *
- Billing and Reimbursement Practices
- Notice of Privacy Practices
- Patient Information Release *
- Delivery Authorization *
- Emergency Policies & Procedures for Patients
- Community Resource List

**** I have completed the documents (marked with an *) required by Charm Medical Supply in order to initiate the services I've requested. ALL five (5) documents requiring a signature will be returned in the self-addressed, stamped envelope provided to me by Charm Medical Supply.***

Patient Name (Please Print)

X

Patient or Patient Guardian/Caregiver Signature

DATE