



PATIENT AGREEMENT

Social Security # (Mass Health RID):	Health Insurance ID#:
Patient Name:	
Address:	Telephone #:
Type of Healthcare Product and/or Service:	Effective Date:

REQUEST FOR PROVISION OF SERVICES

I understand that by signing this agreement, I indicate my wish to purchase health care products or service or both from Charm Medical Supply, a division of TMed Holdings, Inc.

INDICATION OF MEDICAL RESPONSIBILITY

I understand that I am signing under the supervision and control of my attending physician. I understand that Charm Medical Supply's services do not include diagnostic, prescriptive or other functions typically performed by licensed physicians, and that my physician is solely responsible for diagnosing and prescribing drugs, supplies, equipment and services for my condition and otherwise supervising and controlling my medical care.

RELEASE OF INFORMATION

I authorize my insurer(s), and any other third party payor who provides me with coverage, to disclose to Charm Medical Supply any information regarding such coverage, including, but not limited to, payments made by such insurer(s) or third party payor(s) to me, for home healthcare products or services rendered to me by Charm Medical Supply, and the scope and extent of coverage available from time to time. I authorize all medical personnel to provide information to Charm Medical Supply concerning my medical history as it may relate to my home services and health care product needs. If my primary insurance changes, I agree to notify Charm Medical Supply.

CREDIT CHECK AUTHORIZATION AND CREDIT TERMS

Charm Medical Supply is authorized to verify any information I have disclosed and perform a credit investigation for the purpose of extending credit for the purchase or rental of medical equipment. In addition, Charm Medical Supply may answer questions from other creditors about my credit and account experience with Charm Medical Supply.

ASSIGNMENT OF BENEFITS

I authorize Charm Medical Supply to request on my behalf, and to collect directly, all public and private insurance coverage benefits due for products and services supplied by Charm Medical Supply. In the event payments for insurance benefits are made directly to me, the payee, I will endorse all checks for payment to Charm Medical Supply. I accept all responsibility for overpayments per statement.

EXTENDED MEDICARE ASSIGNMENT

- I certify that the information given by me for payment under Medicare (Title XVIII of the Social Security Act) and/or other medical insurance is correct.
1. The patient, if physically and mentally competent, must sign on his/her behalf. If he/she cannot sign for himself/herself, a representative payee as designated by the Social Security Administration, or a legally appointed guardian, may sign. The source of the signatory's authority should be stated (e.g. "Social Security appointed Representative Payee," or "court appointed guardian," etc.).
 2. This form is used in lieu of the patient's signature on the "Request for Payment" HCFA-1500 (I-84) and is therefore an extension of that form. Anyone who misrepresents or falsifies essential information in making Medicare claims may, upon conviction, be subjected to fine and imprisonment under Federal law. Furthermore, in signing, the beneficiary authorizes any holder of medical or other information about himself/herself to release to the Social Security Administration or its intermediaries or carrier any information needed to process related Medicare claims. He/she further permits a copy of the authorization to be used in place of original.
 3. On assigned claims, the provider agrees to accept the Medicare carriers' allowable amount as the full charge for covered services; the patient is responsible for the deductible, co-insurance and non-covered services. This authorization may be cancelled by mutual agreement of the provider and customer at any time by written notice to the Medicare Center.

I request payment under the Medical Insurance Part of MEDICARE be made directly to Charm Medical Supply for service furnished me during the effective period of this authorization. I have read and I agree to the release of information as specified in Paragraph 2 above.

The undersigned certifies that he/she has read the foregoing and received a copy. The undersigned also certifies that he/she is the patient, or is duly authorized by the patient as patient's general agent, to execute the above and accept its terms.

NOTE: A copy of this Agreement and Consent shall be considered the same as an original.

Manager: PETER TALLAS

Telephone: 877-94-CHARM

PATIENT COPY

Please retain for your records



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Manager: PETER TALLAS Telephone: 877-94-CHARM

X

Patient/Spouse/Guarantor/Guardian Signature Relationship to Patient Date

Witness Date

RETURN THIS COPY- SIGNED AND DATED- TO CHARM MEDICAL SUPPLY