CHARM
MEDICAL SUPPLY

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:

Patient's Rights and Responsibilities *

Patient Agreement *

Delivery Authorization *

Patient Information Release *

Patient Acknowledgement of Receipt *

DMEPOS Medicare Supplier Standards

Notice of Privacy Practices

Patient Complaint/Grievances Policy

Billing and Reimbursement Practices

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.***

«PDPatient_First_Nme» «PDPatient_Last_Name»
Patient Name

X_____
Patient or Patient Guardian/Caregiver Signature **DATE**

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

33 Riverside Dr Suite 200, Pembroke, MA 02359
781-829-9813 (local), 877-94-CHARM (toll free), 781-829-9836 (fax)
www.charmmedical.com