CHARM MEDICAL SUPPLY

ACKNOWLEDGEMENT OF DOCUMENTATION RECEIPT AND ASSIGNMENT OF BENEFITS STATEMENT

I, the undersigned, acknowledge that I have *received, read and understand* the following documents provided to me from Charm Medical Supply. **The documents (marked with an*) are required by Charm Medical Supply to be signed and returned to Charm Medical Supply in order to initiate the services I've requested have been completed.**

I understand that the **Notice of Privacy Practices (NOPP) Acknowledgement Form *can only be completed by the individual client themselves, unless the individual has been assigned a court appointed legal guardian or is a minor child-*** *in either of these scenarios the person legally responsible for the individual must be provided with the NOPP and sign the acknowledgment.*

- This Acknowledgement of Documentation Receipt and Assignment of Benefits Statement *
- Notice of Privacy Practices & Notice of Privacy Practices Acknowledgement Form*
- Patient Agreement
- Patient's Rights and Responsibilities
- DMEPOS Medicare Supplier Standards
- Patient Complaint/Grievances Policy
- Billing and Reimbursement Practices
- Emergency Policies & Procedures for Patients
- Community Resource List

X_____ _____ _____

Acknowledgement of Documentation Receipt: Patient or Authorized Party on Patient Behalf **Relationship to Patient** **Date**

_____

Patient Name

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 provided 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.

And or if a Medicare Beneficiary:

Extended Assignment of Benefits: 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. I have read and understood the Extended Assignment of Benefits statement on the Patient Agreement page contained within my patient information packet provided by Charm Medical Supply. I request payment under the Medical Insurance Part of Medicare be made directly to Charm Medical Supply for service furnished to me during the effective period of this authorization. **The patient, if physically and mentally competent, must sign on his or her own behalf.** If he or she cannot sign for himself / herself a representative payee as designated by the Social Security Administration, a legally appointed guardian, a relative, friend, representative of an institution providing him/her care or support or a representative of a governmental agency providing assistance may sign. The source of the signatory's authority should be stated when the patient is unable to sign on his / her own behalf.

X_____ _____ _____

Assignment of Benefits: Patient Signature (or Other Authorized Party on Behalf of the Patient) **Relationship to Patient** **Date**

RETURN THIS COPY- *SIGNED AND DATED IN BOTH AREAS MARKED "X"-*
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