13910 Lynmar Blvd. Tampa, FL 33626
5626 Randolph Blvd. Ste 2, San Antonio, TX 78233
813-792-3560, 866-834-7473 toll free, 877-490-9111 fax

**TO BE COMPLETED BY THE PATIENT OR CAREGIVER:**

**PLEASE COMPLETE, SIGN AND RETURN BY MAIL OR BY FAX TO 877-490-9111**

## INSURANCE PAYMENT AUTHORIZATION

I REQUEST THAT PAYMENT OF AUTHORIZED INSURANCE OR MEDICARE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO ONE SOURCE MEDICAL GROUP LLC., FOR ANY SERVICES FURNISHED ME BY THE PHYSICIAN/SUPPLIER. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE INSURANCE COMPANY OR TO CMS (CENTERS FOR MEDICARE AND MEDICAID SERVICES, FORMERLY KNOWN AS HCFA) AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE TO RELATED SERVICES.

*In Medicare assigned cases, the supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services.* Coinsurance and the deductible are based upon the charge determination of the Medicare carrier. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I will not be receiving the same product(s) from another Medicare approved company, as Medicare/Insurance will only pay one provider at a time.

## ACKNOWLEDGEMENT OF RECEIPT OF PATIENT HANDBOOK

I have received the Patient Handbook from One Source Medical, either today or in the past. I am either a patient or a representative of the patient signing on his/her behalf. A representative from One Source Medical Group has explained the various sections in the packet and I have had an opportunity to ask questions. I have received the following information:

- Patient Rights and Responsibilities
- How to Register a Complaint
- Notice of Privacy Practices
- Important Insurance Information
- After Hours Calls
- Disaster Preparedness – Special Needs Registration
- Warranty Information
- Medicare Supplier Standards Information
- Community Resources
- Written instructions (if applicable)
- Cleaning instructions (if applicable)
- Customer Satisfaction Survey

In addition to the booklet, I have been previously trained, understand, and demonstrated the use of the following equipment that is being provided to me:

☐Diabetes testing supplies
☐Insulin pumps and supplies
☐Incontinence Supplies
☐Catheters & supplies
☐Nebulizer equipment
☐ Enteral Feeding pump & Supplies
☐Ostomy supplies
☐Tens Unit/Supplies
☐Other_____

I authorize One Source Medical Group to contact me by phone for the purpose of providing medical supplies prescribed by my physician. I authorize the following individuals to receive information about supplies or equipment that I receive from One Source Medical Group.

Name: _____ Relationship_____Phone_____

Patient Name: _____ Date of Birth _____

Address: _____

City, State, Zip _____

Email address: _____

Emergency Contact name: _____ Phone: _____

_____

**Authorized Signature** **Date** **Relationship if other than patient:**

*One Source Medical Group, LLC understands that the medical information requested above is Protected Health Information (PHI) and is the minimum necessary to execute delivery of client services. Please understand as a link in the "Chain of Trust" all PHI will remain confidential as mandated by the Treatment, Payments and Healthcare Operation Laws mandated by HIPPA.*