ENTERAL PUMP RENTAL AGREEMENT

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

One Source MEDICAL GROUP

INSURANCE COMPANY_____

MEMBER NAME:_____ **Cell phone**_____

ADDRESS:_____

CITY, STATE, ZIP_____

One Source Medical Group is providing the following equipment which has been arranged through your physician and your insurance.

This equipment is being provided as monthly RENTAL and remains the property of One Source Medical Group/Medical Specialties Distributors.

☐Enteralite Infinity Pump, Adapter and Pole Clamp
☐Covidian Kangaroo Joey, adapter and pole clamp

Serial numbers:_____

You are required to contact One Source any time you change your phone number, address, insurance, physician or other information.

If your doctor discontinues the order for feeding pump, you find you no longer need this equipment or we are not in network with a new insurance plan, you must return it to our company. Please contact us at 866-834-7473 and we will provide a pre-paid return method.

I _____ understand that the equipment listed above is being provided to me as a **rental only** for the member referenced above. I will notify One Source if I move, change my telephone number, insurance company, or any other information listed above. If I change my insurance plan and One Source is out of network with my new insurer, I understand I will be given ample time to find an alternate supplier. If the pump malfunctions or is not working properly, I will contact One Source to exchange the equipment. I will keep a back up feeding plan per my doctor's instructions in case the pump malfunctions. I will keep it clean and will use it according to the manufacturer's manual which were included with the equipment. I have been previously trained to use the equipment that has been provided to me and I have been given a copy of the patient handbook which outlines my rights and responsibilities. I authorize One Source to bill the insurance on file for these services. I am responsible for returning the equipment when no longer in use, out of network with the insurance or any other reason for non-coverage by your insurance.

Caregiver/Responsible party Printed Name:_____

Signature:_____Date:_____

Emergency contact name:_____ phone #_____