ELECTROMED, INC.
Creating superior care through innovation®

Patient No._____

PATIENT AGREEMENT AND CONSENT FORM

Patient Name: _____

Authorized Representative Name and Phone No. if Applicable: _____

Home Address: _____

Insurance Plan(s):_____

Other Entities (ex. Physicians, Clinics):_____

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

I consent to the use and disclosure of my Protected Health Information (PHI) by Electromed, Inc. and its affiliates for treatment and payment purposes. I authorize Electromed to communicate with health care providers, as necessary, who are involved in my care. The Notice of Privacy Practices, which outlines Electromed's privacy practices and my individual rights and responsibilities under HIPAA, is available for review on Electromed's website **www.electromed.com**. This authorization includes all PHI about me that has been created or received by Electromed. I can contact the Electromed Privacy Officer toll free at 1-800-462-1045 ext. 3384 if I have questions or concerns about Electromed's Notice of Privacy Practices or my individual HIPAA rights. This authorization will remain in effect for a period of one (1) year or until billing and/or appeals have been completed or until I revoke the authorization in writing, whichever is earlier.

Assignment of Benefits

I authorize Electromed to submit claims and other information necessary to bill my health insurance and/or benefit plan (Plan). I also authorize and request that any and all payments for the purchase and/or rental of equipment be made directly to Electromed or its assignments and/or an authorized distributor. I agree to endorse and forward any payments made to me by my Plan to Electromed for services billed under this Agreement.

Appeal Consent

If my Plan denies coverage for this equipment, I give permission for Electromed to initiate and act as my representative in the appeal process. I agree to fully cooperate with Electromed during the appeal process. I understand Electromed will not charge me to appeal with my Plan. I may revoke my permission to appeal at any time. I understand that Electromed makes no guarantee of a favorable appeal outcome.

Patient Compliance Responsibility

I understand that my Plan may require treatment compliance information from me. I agree to respond to Electromed's request and to provide this information promptly. If I do not cooperate, reimbursement for this equipment may be adversely affected.

Patient Financial Responsibility

Electromed will make every effort possible to obtain complete payment from my Plan.

I understand that I will be responsible for payment of any amount not covered by my Plan, including but not limited to copayments, coinsurance, deductibles, non-covered services. In the event the equipment needs to be returned, call the Electromed toll free number at 1-888-966-2525 for return instructions.

Additional Terms and Conditions

The person signing this authorization may receive a copy of this authorization upon request. NOTE: A duplicate copy of this document shall be considered the same as the original. By signing this, I agree to all the terms and conditions stated above.

Patient Signature: _____ **Date:** ___/____/____

Authorized Representative Signature (if applicable):_____ **Date:** ___/____/____

If signed by Authorized Representative, please confirm the nature of your relationship with Patient:

_____ **and check reason why Patient is unable to sign:**

_____ **Patient is a minor under the age of 18 years and parent or legal guardian signature is required.**

_____ **Patient is not competent to give consent due to a physical or mental condition.**

_____ **Other (please specify):** _____

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