

**PATIENT AGREEMENT AND CONSENT FORM**

**A** Patient Name: John M. Smith      **B** Date of Birth: 12/19/1963  
**C** Home Address: 1234 First Ave, Springfield, IN 55554  
**D** Insurance Plan(s): BCBS of Indiana and IN Medicaid or other plan administering IN Medicaid benefits  
**E** Other Entities (ex. Physicians, Clinics): Smith Pulmonary care, Dr. Jones, and South Metro Hospital

**Health**



## How to Complete the SmartVest<sup>®</sup> Patient Agreement and Consent Form

A completed patient agreement and consent form expedites the time in which Electromed can gain approval for reimbursement and ship the SmartVest<sup>®</sup> System directly to the patient.

Follow these steps to make sure that your patient receives their SmartVest System quickly.

**Please complete every field.**

- A** Write in **the patient's full legal name**.
- B** Fill in **the patient's complete date of birth**.
- C** Add **the patient's home address** including their **zip code**.
- D** Write in **all of the patient's active health insurance plans** by plan name.
- E** Add **other entities**, meaning any primary care physician, pulmonologist, hospital, or clinic that may have medical records related to the patient's pulmonary health.
- F** Have **the patient sign** and **date** the patient agreement and consent form.

*Medicare coverage should be listed as 'Medicare or other plan administering Medicare benefits.' Medicaid coverage should be listed as 'Medicaid or other plan administering (state name) Medicaid benefits.'*

*By listing Medicare and Medicaid plan information this way, the patient agreement and consent form remains valid if the patient switches between straight Medicare or Medicaid and/or managed care plans.*

*The patient can sign the patient agreement and consent form if over 18 years and is competent to give consent. Clinic staff are not authorized to sign for patients.*

*Authorized representative, power of attorney, legal guardian, or parent can sign if the patient is a minor under the age of 18 years or is not competent to give consent due to a physical or mental condition. Please note the signer's relationship with the patient and check the reason why the patient can't sign.*

**F** Patient Signature: John M. Smith      Date: 6 / 20 / 17  
 Authorized Representative Signature (if applicable): \_\_\_\_\_ Date:  / /  
 Authorized Representative Name and Phone No. (if applicable): \_\_\_\_\_

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): \_\_\_\_\_

# Prescribe the SmartVest® Solution for Airway Clearance

The SmartVest® Airway Clearance System is designed to provide an effective, convenient, and comfortable treatment for patients with chronic lung conditions.

Visit [www.smartvest.com](http://www.smartvest.com) to learn more.

## ***ELECTROMED, INC.***

Making life's important moments possible — one breath at a time.®

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 [www.facebook.com/SmartVestAirwayClearanceSystem](https://www.facebook.com/SmartVestAirwayClearanceSystem)

## **Engineered and Built in Minnesota**

Electromed, Inc., is committed to a strong and continuing program of innovation for the benefit of patients and their caregivers.



Accredited by The Joint Commission

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AIRWAY CLEARANCE SYSTEM

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