Knight Medical Supply L.L.C.

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STILLWATER, OK 74074-4621
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Toll Free: (800) 267-6531

Patient Authorization & Education Checklist

Patient Name: ______________________________ Customer ID#: ______________

Equipment / Item to be supplied:____

(*Provide patient with copy and check when reviewed*)

Mission Statement	Return / Exchange Policy	Supplier Standards
Hours of Operation/After Hours	Rights & Responsibilities	Notice of Privacy (HIPAA)
Resolving Complaints	Capped Rental / Routine Purchase items	General Environmental Safety

(See Attachments for Above Items)

Medical Information Authorization
I hereby authorize release of my Medical Records to KNIGHT MEDICAL SUPPLY L.L.C. **(the provider)** I also authorize **the provider** to furnish to my insurance carrier(s), any medical history, services rendered, or treatment needed in order to process insurance claims related to the equipment/services provided.

Assignment of Insurance Benefits
I request that payment of authorized insurance benefits be made on my behalf to **the provider** for any items or services furnished to me by **the provider.** I understand that when my insurance company does not accept "Assignment of Benefits", payments may be sent directly to me from my insurance company. I understand that I am obligated to endorse and directly send such payments to **the provider** for payment of my bill, deductibles, and/or co-pays.

Financial Responsibility
It has been explained to me and I fully understand that I am responsible to **the provider** for all charges not covered by my insurance.
I understand that if my insurance company, employer, or any other third party payer refuses to pay the rental and/or purchase price(s) of the above items, or delays payment beyond 90 days of my receipt of the item(s), or in the event that I have no insurance coverage or third party payer, that I will be responsible for said payments and will make prompt reimbursement within 30 days of notification by **the provider** for all charges.

Acceptance of Equipment/Services
I understand that by signing this agreement, I authorize provision of products and/or services to me by **the provider.** I also understand that the products and services provided are prescribed by a physician and that I must remain under his/her supervision during the course of my care. The equipment and/or supplies are not intended to be used as a life-support device, nor will **the provider** or manufacturer assume any responsibility for the success or failure of any treatments administered by this device. **The provider**, Distributor's and/or Manufacturer's liability shall be limited to repair or replacement.

Equipment Set-up and Instruction

Environmental/Safety check (Home Assessment)	Explain Physician prescription for equipment and/or supplies
Review printed education material/safety precautions	Perform safety & operation check
Instruct alternate caregiver (If appropriate)	Explain after hours / Emergency procedure
Assemble and install equipment	Provider's address, phone & business hours
Perform demonstration & verbal instruction	Explain need to contact provider if patient status changes
Explain procedure for non-operating equipment	Explain warranty coverage, Length ______________
Customer's responsibility for maintenance & cleaning	Satisfaction Survey

Observe patient/caregiver proficiency in proper use and care of equipment and/or supplies by return demonstration of equipment

I acknowledge and understand the entire contents of this document, including attachments.

Received by

Name: (Printed)________________________________ Date:______________________
Patient/Customer Signature:__________________________ Time:______________________
Authorized Representative:___________________________ Relationship:________________
Reason why patient/customer cannot sign:____
Provider Representative:____________________________ Title:______________________