



Patient Consent Form

Patient's Name:

Phone:

Address:

City, State, Zip:

Date of Birth:

STATEMENT TO PERMIT PAYMENT OF INSURANCE BENEFITS TO PROVIDER, PHYSICIAN AND PATIENT

I request that payment of authorized Medicare and/or private insurance benefits be made either to me or on my behalf to Duke Medical Supply, Inc. (Duke Medical) for any supplies furnished to me by Duke Medical. I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services and/or my private insurance, and its agents, any information needed to determine these benefits for related services.

I understand that Duke Medical reserves the right to review all agreements on an individual basis to determine the continued acceptance of assignment for Medicare and/or any other medical insurance companies. In the event medical necessity no longer exists or my payor no longer deems my supplies to be covered, I understand I must return the unopened, reusable supplies to Duke Medical so they may refund my insurance. I agree to call before returning the supplies.

I have received and understand my Customer Bill of Rights, Medicare DMEPOS Supplier Standards, Notice of Privacy Practices, and the Duke Medical Supply Warranty Information. I agree that Duke Medical may contact me in the future, via telephone or other means of communication, regarding ordering medical supplies.

Patient's Signature

Date

Note: If the patient is physically or mentally unable to sign, a representative may sign on the patient's behalf. In addition, the representative's signature, date signed, representative's name (print), address, relationship to the patient and reason why the patient cannot sign must be listed below.

Representative's Signature

Date

Representative's Name (Print)

Address

Relationship

Reason Patient Cannot Sign

PLEASE SIGN AND RETURN TO:

DUKE MEDICAL SUPPLY
300 BILTMORE DR
SUITE 350
FENTON, MO 63026