Patient Consent Form

Patient's Name: **Phone:**

Address:

City, State, Zip:

Date of Birth:

STATEMENT TO PERMIT RELEASE OF MEDICAL INFORMATION TO DUKE MEDICAL SUPPLY, INC.: I authorize any holder of medical or other information about me to release any and all requested information (including medical records) to Duke Medical Supply, Inc. This information is to be used solely for billing purposes to the Centers for Medicare and Medicaid Services (CMS) and/or my private insurance. I understand Medicare and/or my private insurance may request this information to determine coverage and eligibility.

STATEMENT TO PERMIT PAYMENT OF INSURANCE BENEFIT TO PROVIDER AND/OR 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.

STATEMENT OF MEDICAL NECESSITY DETERMINATION: 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.

ACKNOWLEDGEMENT OF RECEIPT: I have reviewed my Customer Bill of Rights, Medicare DMEPOS Supplier Standards, Notice of Privacy Practices, and Duke Medical Supply Warranty Information online at www.dukemedicalsupply.com. I understand that a copy of this information is also available to me upon request from Duke Medical. I agree that Duke Medical may contact me in the future, via telephone or other means of communication at my request, 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. Power of attorney documentation may be requested if necessary.

Representative's Signature Date

Representative's Name (Print)

Address

Relationship

Reason Patient Cannot Sign

Please return completed forms and copies of insurance cards to:

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