ADVANCED
HEALTH SERVICES, INC.

YOUR SOURCE FOR QUALITY PAP CARE AND SUPPLIES

Patient Name: ____

Date of Birth: _____/____/___________

Phone: _____________________

Current Address: ____

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CHAP Community Health Accreditation Partner

PATIENT SUPPLIES CHECKLIST

It is our goal to review the operation and fit of the above equipment so that you will be able to understand the proper use and safety of the prescribed equipment ordered for you. Advanced Health Services has reviewed and advised patient of the following:

- The patient consents to be treated with equipment provided by AHS.
- The patient has been given a copy of their Rights and Responsibilities.
- The patient has been provided a copy of the Privacy Act Policy.
- The patient fully understands Advanced Health Services policy on resuscitation during clinical set up.
- The patient fully understands how to assemble and use the mask and or headgear.
- The patient is able to verbalize cleaning instruct ions for the mask, tubing, filter, and water chamber.
- A copy of supplier standards was supplied.
- The patient has read and understands the Assignment of Benefits.
- The patient understands never to attempt to repair the equipment and to contact Advanced Health Services with any malfunctions.
- A contact number was left with the patient for any quest ions or concerns.
- The patient understands the complaint process.
- The patient understands how to contact AHS after hours.

Patient Signature: ____________________________________

Advanced Health Services Clinician: ____________________________________

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ASSIGNMENT OF BENEFITS

I hereby authorize payment of medical benefits for my Advanced Health Services products directly to Advanced Health Services. I further authorize the release of any medical information required by Advanced Health Services to process an insurance claim on my behalf. A copy of this authorization will be sent to my insurance company, if requested. The original authorization will be kept on file by Advanced Health Services.

In case of an insurance company's refusal to pay Advanced Health Services, I will assume full responsibility for the payment. If my insurance company should pay benefits directly to me for any merchandise provided by Advanced Health Services, I will either endorse all checks from my insurance company as "Pay To The Order of Advanced Health Services " or write a personal check to Advanced Health. I will notify Advanced Health Services immediately of any change in my insurance coverage.

I further authorize the release of any information necessary to process such claims, including medical record information from a doctor or hospital. I authorize Advanced Health Services to allow confidential review of the file of my treatment if requested by any state, federal, or accreditation agency.

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Signature of Patient **Date**

If you are not the patient, please fill out the information below.

____

Signature **Print Name**

____

Address **Phone Number**

EMAIL CONSENT FORM

- Yes, I give Advanced Health Services permission to email me at the following email address regarding my follow up PAP care.

  Email: ____

- No, I do not give Advanced Health Services permission to email me

Patient Signature: _______________________________

Date: _______________________________

ADVANCED HEALTH PAYMENT FINANCIAL POLICY

To better serve our patients, we understand the need for clear communication of our financial policies. Please understand that payment for service is an important part of our professional relationship and we strive to be good stewards of your healthcare dollars. **Prior to receiving products, we request a form of payment on file to satisfy any balances that are the responsibility of the patient.** Some insurance plans may require a monthly rental of your equipment. This means you may incur a monthly rental charge that will be subject to our Automatic Payment process. If you have additional questions regarding your plans rental requirements, please contact your insurance carrier or our billing department. We accept Visa, MasterCard, Discover, and American Express. All payment information will remain confidential and securely stored by our PCI compliant merchant processor.

Payment Authorization for Automatic Payment

☐ **I hereby authorize Advanced Health Services, Inc. to charge the payment method I have provided for any balances that are the responsibility of the patient.**

☐ **I decline Auto Pay at this time. I understand I will be billed for any patient balance due and will be responsible for said balance.**

Print Name: ___________________________________ **DOB**____/____/_______

Signature: ____

Date: _________________________

AUTHORIZATION TO ASSIGN BENEFITS TO PROVIDER & RELEASE OF MEDICAL INFORMATION:

I understand the Advanced Health Services, Inc. financial policy requires that I maintain a form of payment on file to pay for any charges not covered by my health insurance policy. I authorize Advanced Health Services, Inc. to execute transactions on this account. I consent to the use of this payment method without my signature on the individual transactions in satisfying my obligations. I understand refunds are not executed once a payment transaction has processed. I understand that a photocopy or fax of this agreement will serve as an original, and this payment authorization cannot be revoked unless done so with 30 day written notice to the provider.