MIDWEST COMPRESSION
Pneumatic Compression Devices

PATIENT CONSENT

PATIENT CONTACT INFORMATION

NAME | **DATE OF BIRTH**

My address is a: ☐ Private home/apartment ☐ Facility*
**Assisted Living, Skilled Nursing, Group Home, etc.*

Preferred language (if other than English):

Phone numbers:
(_____) _____ ☐ HOME ☐ CELL ☐ WORK
(_____) _____ ☐ HOME ☐ CELL ☐ WORK

Phone numbers:
(_____) _____ ☐ HOME ☐ CELL ☐ WORK

Email address: _____

By providing my contact information, I authorize Midwest Compression to contact me regarding my order, account or other services or products provided by Midwest Compression. A detailed description of my rights was provided to me in the Notice of Privacy Practices. Midwest Compression will never disclose your personal information to any unrelated third-parties. You may view our full privacy statement on our website.

FAMILY/LEGAL GUARDIAN/EMERGENCY CONTACT(S)

NAME **RELATIONSHIP** **PHONE**
☐ Authorized to accept shipment, set up payment plans, and schedule training on my behalf
☐ Authorized to discuss PHI/emergency contact

NAME **RELATIONSHIP** **PHONE**
☐ Authorized to accept shipment, set up payment plans, and schedule training on my behalf
☐ Authorized to discuss PHI/emergency contact

☐ Patient does not wish to share Family/Legal Guardian/Emergency Contact information with Tactile Medical.

CONSENT FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

– I understand that Midwest Compression originates, collects and maintains paper and/or electronic records describing my Protected Health Information (PHI) such as health history, diagnosis, symptoms, test results, etc. I consent to the use and disclosure of my PHI by Midwest Compression, its staff, and its business associates for treatment, payment and healthcare operations.
– I understand I have a right to request restrictions or revoke any use and/or disclosure of my PHI by Midwest Compression. I understand that the Midwest Compression Notice of Privacy Practices is included in the device package and that I can contact customer service at 1.800.883.1549) if I have questions. This authorization is effective for five years unless otherwise provided by law.
– I authorize and consent to the release by my healthcare providers to Midwest Compression and any insurance company(ies), all PHI necessary to complete my equipment order.

ASSIGNMENT OF BENEFITS & FINANCIAL RESPONSIBILITY

I assign payment of medical benefits to Midwest Compression (Premer Medical) and direct any insurance (payer) to make payment on my behalf directly to Midwest Compression (Premier Medical) for medical equipment provided. Any costs not covered by my insurance are my responsibility. If for any reason insurance will not complete the purchase of the device (including change of insurance), I must 1) pay the remaining cost out of pocket or 2) return the device and pay my assigned balance. In the event my insurance makes payment directly to me for the medical equipment, I am responsible for ensuring payment in full is made promptly to Midwest Compression.

RETURN POLICY

Midwest Compression does not accept returns or provide refunds for products once the original packaging has been opened. Unopened products may be returned within sixty (60) days of the date of shipment. If you receive a product(s) that is incorrect due to a Midwest Compression error, Midwest Compression will exchange the product(s) if the Company is notified within sixty (60) days of the date of shipment. For equipment rented through insurance, the patient is responsible for outstanding financial obligations for the period in which they had the product.

PATIENT SIGNATURE

I agree to all the terms and conditions listed above.

PATIENT OR AUTHORIZED SIGNER NAME* (PLEASE PRINT) **SIGNATURE** **DATE**

*Authorized Signer can be Legal Guardian, Power of Attorney, or Family member.