PO Box 1830
Conway, NH 03818
Phone: 800-223-9310
Fax: 603-356-3141

Admission of Informed Consent for Austin Medical Products, Inc.

Patient Name:	Date of Birth:
Address:	Phone Number:

Request for Provision of Services

The undersigned, being the above-named patient, legal guardian or representative payee (the "Patient"), understands that by signing this *Admission of Informed Consent*, you agree to receive services provided by Austin Medical Products, Inc.

Acknowledgement of Medical Responsibility and Informed Consent

The undersigned understands that 1) Patient is under the supervision and control of his/her attending physician; 2) Patient physician has prescribed the medical care and/or services noted as part of Patient's treatment; 3) Austin Medical Products, Inc. services do not include diagnostic, prescriptive or other functions typically performed by licensed physicians; and 4) Patient's physician is solely responsible for diagnosing and prescribing medical equipment, supplies, services or other therapies for Patient's condition and for otherwise controlling Patient's medical care. The Patient has been informed that the use of the AMPatch® could cause skin irritation or potentially an allergic reaction, and in this situation the Patient should consult their health care professional. If the Patient deems the incident to be an emergency, they have been instructed to call 911.

Agreement to Pay

The undersigned agrees to pay for all supplies and equipment provided by Austin Medical Products, Inc. As we do not accept assignment from any insurer, including Medicare, payment by the patient is required either by credit card, debit card or paper check when products are ordered. Austin Medical Products, Inc. will file claims to Medicare for Medicare beneficiaries whose primary insurer is Medicare, so they may be reimbursed by Medicare. Any amount uncovered by Medicare is the Patient's responsibility.

Product Warranty

Every product sold by Austin Medical Products, Inc. is warranted for 6 months. If any product is received in a damaged or a defective condition, the product will be replaced free of charge.

Authorization for Release of Medical and Other Information

The undersigned hereby authorizes 1) all medical personnel to disclose information to Austin Medical Products, Inc. concerning the Patient's medical history and condition as it may relate to the services/supplies provided to Patient by Austin Medical Products; and 2) any holder of medical or other information about Patient to release to the Center for Medicare and Medicaid Services and it's agents any information needed to determine applicable benefits to process claims for equipment or supplies provided by Austin Medical Products and or to conduct quality assurance or utilization reviews. This release shall continue until revoked in writing by Patient or the undersigned.

Assignment of Benefits

The undersigned acknowledges that Austin Medical Products, Inc. does not accept assignment from any insurer, including Medicare. All equipment and supplies must be paid for in full at time of purchase. Claims will be filed with Medicare by Austin Medical Products, Inc. on the Patient's behalf so the Patient may be reimbursed by Medicare. Any amounts uncovered by Medicare are the Patient's responsibility.

Notice of Privacy Practices Acknowledgement

The undersigned hereby acknowledges that they have received the information packet containing: *The Notice of Privacy Practices* from Austin Medical Products, Inc. and have been provided an opportunity to review and understand its contents.

Miscellaneous

The undersigned certifies that the information provided to Austin Medical Products, Inc. by or on behalf of Patient under Medicare is correct. Patient, if physically and mentally competent, must sign this *Admission of Informed Consent* on his/her own behalf. If Patient cannot sign for himself/herself, the source of the undersigned's authority to sign on behalf of Patient must be stated. This *Admission of Informed Consent* is used in lieu of the Patient's or his /her representative's signature on the "Request for Payment" HCFA-1500 forms and thus, is an extension of those forms. Any person who misrepresents or falsifies information making a Medicare claim may, upon conviction, be subjected to fines and imprisonment under Federal Law. Penalties may also result from falsification or misrepresentation of health insurance claims. A copy of this *Admission of Informed Consent* may be used in place of the original.

The undersigned certifies that 1) he/she is the Patient or is duly authorized to execute this *Admission of Informed Consent* and accept its terms on behalf of the Patient and 2) he/she has read the foregoing and received a copy of the following: **Admission of Informed Consent, Privacy Practices, Patient Bill of Rights, DEMPOS Supplier Standards, Written Description of Services, Patient Authorization and Medical Release forms, and written instructions on the proper use of the AMPatch®.**

Patient Signature	Print Name		Date
Patient Representative (If Any)	Print Name	Relationship to Patient	Date

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Medical Release Form for Austin Medical Products, Inc.

Patient Name:	Date of Birth:
Address:	Phone Number:

My Doctor is:

Doctor's Name:	Doctor's Phone:
Doctor's Address:	Doctor's Fax:

I authorize Dr._____ to release my medical records to Austin Medical Products, Inc. This release allows Austin Medical Products, Inc. to receive a copy of, examine, and photocopy or otherwise reproduce the records for the purposes of obtaining medical supplies and processing Medicare claim forms. This form will remain in effect until cancelled in writing by the undersigned.

Records that you are authorized to release include all portions of medical records, including hospital and physician office records.

I further authorize and request that you accept a machine copy of this authorization as the original.

Patient Signature Print Name Date

Patient Representative (If Any) Print Name Relationship to Patient Date

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Authorization to Bill Medicare for Austin Medical Products, Inc.

Patient Name:	Date of Birth:
Address:	Phone Number:

I authorize Austin Medical Products, Inc. to release to the Health Care Financing Administration and its agent any medical or other information necessary to determine benefits payable for related services or products. I also request that payment of authorized Medicare benefits be made to me for products or services furnished to me by this supplier.

Patient Signature | Print Name | Date

Medicare Number

Patient Representative (If Any) | Print Name | Relationship to Patient | Date

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Delivery Statement Form for Austin Medical Products, Inc.

Patient Name:	Date of Birth:
Address:	Phone Number:

Notice to Medicare Beneficiary:

Based on the zip code of your primary residence, approximate delivery time for packages/products ordered will be:

UPS Ground: _____ (Not counting day of package pick-up)

Priority Mail: _____(Not counting day of package mailing)

Expedited shipping methods are obtainable; cost must be calculated at the time of order, as shipping costs are determined by package size, weight and type of expedited shipping.

DATE: _____

Please complete and return in the provided envelope along with any other information requested.

Patient Signature Print Name Date

Patient Representative (If Any) Print Name Relationship to Patient Date

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Equipment Warranty Form for Austin Medical Products, Inc.

Patient Name:	Date of Birth:
Address:	Phone Number:

Products sold by our company are consumable products and are guaranteed to be free of defects at the time you receive them. If, upon receipt, there appears to be a material defect, Austin Medical Products, Inc., will replace, free of charge, any Medicare-covered product that appears to be defective. We will not replace products where a seal has been broken or the product appears to be used.

I have been instructed and understand the warranty coverage on the product I receive.

Patient Signature	Print Name		Date
Patient Representative (If Any)	Print Name	Relationship to Patient	Date

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Emergency Contact Information Form for Austin Medical Products, Inc.

Patient Name:	Date of Birth:
Address:	Phone Number:

Family/next of kin/legal guardian/emergency contact name:
Telephone Number:

Primary caregiver name:
Telephone Number:

Physician responsible for care name:

Please complete and return in the provided envelope along with any other information requested.

Patient Signature	Print Name		Date
Patient Representative (If Any)	Print Name	Relationship to Patient	Date