PROOF OF DELIVERY AND AUTHORIZATION TO RELEASE INFORMATION AND PERMIT PAYMENT OF INSURANCE BENEFITS TO PROVIDER, MEDICAL FINANCE RESOURCES, INC

I assign and transfer any and all rights to receive and or appeal any insurance benefits otherwise payable to me for products or services provided. Any monies that may be sent to me by my insurance company, I will either endorse the check or write a check and send it to Medical Finance Resources, Inc. within 7 days of payment to me. I authorize my insurance company to furnish to any agent any and all information pertaining to my insurance benefits and status of claims submitted.

For Medicare patients: I understand that I have the option to rent or purchase this equipment. I also have the right to purchase any capped rental item at the end of the rental period.

I authorize the release of any medical or other information necessary to process or appeal this claim or service.

The undersigned certifies that he/she is the patient or is authorized by the patient as patients agent to execute this document and accept the terms.

- ☐ I have been informed of privacy practices
- ☐ I have been informed of warranty coverage and user instruction manuals
- ☐ I have been given a copy of Medicare Supplier Standards
- ☐ Product has been assembled
- ☐ Product has been trimmed
- ☐ Product has been molded
- ☐ Other modification to product for specific patient

______________________________	________________
Patient Name (print)	Patient Acct.#
______________________________	________________
Signature of Patient/Agent	Date
______________________________	
Product, Serial Number	