LEWIN MEDICAL SUPPLY
www.lewinmedical.com

Main Office:
165 Oliver Street • Riverhead, NY 11901
Phone: (631) 727-7006 • *Fax:* (631) 727-7008

Branch Office:
3655 Route 112 • Coram, NY 11727
Phone: (631) 716-4040 • *Fax:* (631) 716-2169

CLIENT AUTHORIZATION FORM

Name: _____ Birth Date: _____

ASSIGNMENT OF BENEFITS

I hereby authorize Lewin Medical Supply, hereinafter referred to as the company, to request on my behalf and to collect directly from my third party payor all benefits due to me for services provided by the company. I agree to promptly endorse and forward to the company any and all payments from my third party payor for services rendered by the company

MEDICAL INFORMATION RELEASE

The release of any medical information held by any health care provider that is needed in connection with processing claims for reimbursement or services provided by the company is hereby authorized.

PAYMENT FOR SERVICES RENDERED

I accept full responsibility for payment of any and all monies due to Lewin Medical Supply that is not covered by third party payment. I will pay these monies promptly upon receipt of an invoice. Payment is due 30 days from date of invoice. If not paid in 90 days, the account may be sent to collection and the following fees will be added: $36 collection fee.

WAIVER OF LIABILITY

Your medical insurance is a contract between you and your insurance carrier. Insurance is designed to help cover the cost of medical care; however, it does not relieve you of the responsibility for payment if your insurance does not cover the cost of equipment and supplies. Any billing to an insurance company by Lewin Medical Supply is done as a courtesy and service to our customers. Third party insurance will only pay for services that it determines to be "reasonable and necessary" under your plan. If the insurance company denies the claim for any reason, payment must be made by you.

BILL OF PATIENT RIGHTS AND RESPONSIBILITIES

I acknowledge Lewin Medical Supply has made available to me a copy of the "Medicare Suppliers Standards" and/or a copy of Lewin Medical Supply "Patient Bill of Rights and Client Responsibilities" and/or a copy of Lewin Medical Supply "Reimbursement and Payment Policy". I acknowledge that I have read and understand these policies and I can request a duplicate copy of them anytime by calling (631) 727-7006.

The Authorization was signed by:

_____
Patient/Responsible Party (Please Print)

_____ _____
Signature Witness

_____ _____
Date Effective Date