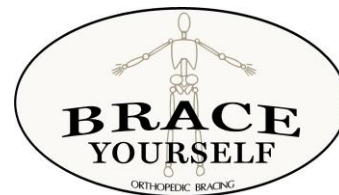


Brace Yourself  
1510 Taylor Plaza East  
PH: 620-805-6500  
Fax: 620-277-7834



## PATIENT DATA SHEET

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ MALE / FEMALE

HOME ADDRESS: \_\_\_\_\_ CITY/STATE/ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ BEST TIME TO CONTACT: \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_ MARITAL STATUS: M S D W

E-MAIL ADDRESS: \_\_\_\_\_

REFERRING PHYSICIAN: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

HOW DID THE INJURY OCCUR: \_\_\_\_\_ DATE OF ACCIDENT: \_\_\_\_\_

TYPE OF ACCIDENT:  HOME  WORK  AUTO  OTHER: \_\_\_\_\_

HOW DID YOU HEAR ABOUT US: TV RADIO PRINT INTERNET WALK-IN OTHER

### EMERGENCY CONTACT INFORMATION:

NAME: \_\_\_\_\_ RELATIONSHIP TO YOU: \_\_\_\_\_

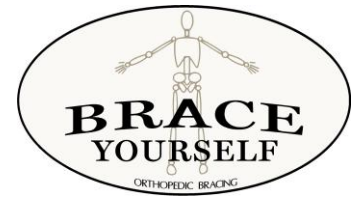
ADDRESS: \_\_\_\_\_ CITY/STATE/ZIP: \_\_\_\_\_

PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

I hereby authorize **Brace Yourself** to release and/or discuss information regarding my medical diagnosis(es) including test results, medications, prescriptions, treatment plans, hospitalizations, billing, financial issues or other pertinent healthcare information to the person(s) listed below. I recognize that I may limit the scope of this authorization and am doing so here:

NAME	NAME
RELATIONSHIP	RELATIONSHIP
PHONE/ADDRESS	PHONE/ADDRESS

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## EQUIPMENT WARRANTY INFORMATION

Brace Yourself will honor all manufacturers' warranties under applicable state law. In addition, the manufacturers' manual will be provided to all Rental beneficiaries for all durable medical equipment provided. If any item delivered to a Rental beneficiary is substandard or unsuitable, Brace Yourself will accept the return of the item or exchange the item. You will NOT be responsible for payment for repair or service for your oxygen equipment supplied by Brace Yourself.

### ASSIGNMENT OF BENEFITS (AOB)

I request that payment of authorized Medicare benefits be made to me or on my behalf to Brace Yourself for durable medical equipment and supplies ordered by my physician. I authorize any holder of medical information about me to release to the Center for Medicare Medicaid Services and its agency any information needed to determine these benefits or the benefits payable for related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If 'other insurance' is indicated in item 9 of the CMS-1500 claim form, or elsewhere on the approved claim form or electronically submitted claims, my signature authorizes releasing the information to the insurer or agency listed. In Medicare assigned cases, the supplier agrees to accept the charge of determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered items. Coinsurance and the deductible are based upon the charge determination to the Medicare carrier.

### PROVIDING CORRECT INFORMATION AND INFORMATION RELEASE

I certify that the information I furnish is true and correct. I acknowledge that it is my obligation to apprise Brace Yourself of any changes of address and insurance. I know it is a crime to fill out this form with facts that I know are false or to leave out facts that are important. I hereby authorize Brace Yourself to submit a claim to my insurance carrier or its intermediaries for all covered prescriptions or durable medical equipment and authorize and direct my insurance carrier or its intermediaries to issue payment directly to Brace Yourself. I hereby authorize Brace Yourself to furnish complete information requested by my insurance carrier or its intermediaries regarding services rendered. I further agree that I am responsible for paying my co-pays, balances, or reasonable late fees which remain after insurance payments have been made, including any cost of collection or legal fee incurred to collect these balances, including reasonable attorney fees. I consent for all jurisdiction to take place in Finney County, Kansas. I also agree for Brace Yourself to store my credit card information if payment is not being made in full at the time of service to be ran at their discretion to pay off any balance, I may have with Brace Yourself or any of its sister companies.

X

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**CUSTOMER/CAREGIVER SIGNATURE**

**IF CAREGIVER, RELATIONSHIP TO PATIENT**

X

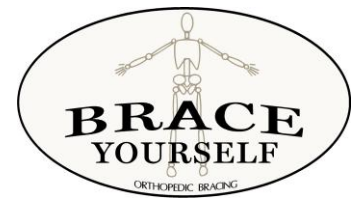
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**WITNESS SIGNATURE**

**DATE**

*This form kept in Patient Record*

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## EQUIPMENT/SUPPLIES PROVIDED

QTY.	DESCRIPTION/HCPC	SERIAL/LOT/MODEL No.	AMOUNT/CHARGE	CO-PAY AMOUNT

<b>TOTAL AMOUNT DUE:</b>		**
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**\*\*PENDING INSURANCE VERIFICATION**

I certify that I have received all of the equipment and supplies listed above in excellent condition. I have been properly instructed on how to use and properly take care of the equipment and supplies. I also understand that in the event that payment of my co-insurance or deductible amounts are not made by my insurance carrier(s), I will be responsible for reimbursing to Brace Yourself any balance owed up to the allowed amount.

I authorize any employee of Brace Yourself to contact me by telephone regarding the equipment and supplies I have received, additional items or supplies that I may need and to discuss any billing and/or accounts receivable information.

X

**CUSTOMER/CAREGIVER SIGNATURE**

**IF CAREGIVER, RELATIONSHIP TO PATIENT**

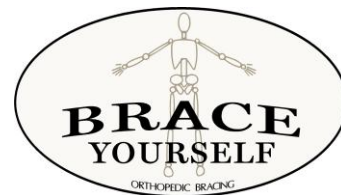
X

**WITNESS SIGNATURE**

**DATE**

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## ACKNOWLEDGMENT OF RECEIPT

Customer Name \_\_\_\_\_ Date: \_\_\_\_\_

Item(s) received: \_\_\_\_\_

### I HAVE RECEIVED THE FOLLOWING INFORMATION:

Hours of Operation and How To Contact Us  
Welcome  
Rights and Responsibilities  
Complaint Procedure / Emergency Preparedness  
Home Safety Information  
Patient Privacy Notification  
Assignment of Benefits  
Equipment Warranty Information  
Equipment/Supplies Provided

Educational and instructional materials provided with each item such as a user manual or the educational materials provided by the manufacturer

### FOR MEDICARE CUSTOMERS *When Applicable:*

Inexpensive or Routinely Purchased Items  
Capped Rental  
ABN (only provided when indicated)

### FOR ALL MEDICARE CUSTOMERS:

30 CMS Supplier Standards

I understand that I must contact Brace Yourself of any changes in my condition or if I am hospitalized

X

**CUSTOMER/CAREGIVER SIGNATURE**

IF CAREGIVER, RELATIONSHIP TO PATIENT

X

**WITNESS SIGNATURE**

**DATE**

*This form kept in Patient Record*