181 Illinois Ave S
Mansfield OH 44905
P 800-797-5696 F 888-805-9060

Release of Information / Assignment of Benefits

Acceptance of Services

I understand that by signing this agreement, I authorize provision of products and/or services to me by **PEDIALIFT LLC.** I also understand that the products and services provided are prescribed by my Physician that it is necessary that I remain under the supervision of my attending physician during the course of my care.

Release of Information

I hereby authorize release of any and all of my medical, billing and insurance records and other information pertaining to my medical history, services rendered, or treatments received from my physician(s) or hospital(s) to **PEDIALIFT LLC**, the Health Care Financing Administration, my insurance carrier(s), or other medical entity. In order to process insurance claims, I also hereby authorize **PEDIALIFT LLC** to furnish to its business associates, including but not limited to its legal counsel, an authorized distributor and/or the Health Care Financing Administration, my insurance carrier(s), or other medical entity, any medical history, billing and insurance information, as well as all detail on services rendered, or treatment needed.

Assignment of Benefits

I authorize direct payment of insurance or other benefits by my insurance company, or other third party payer, including Medicare if I am a Medicare Beneficiary, be made to **PEDIALIFT LLC.** In the event that my insurance carrier does not accept such an "assignment of benefits", I understand that payments may be sent directly to me and that I am legally obligated to endorse and directly send such payments to **PEDIALIFT LLC** within 10 days of receipt, for payment of my bill.

Financial Responsibility

I understand that I am responsible to **PEDIALIFT LLC** for all charges not covered by my insurance. I recognize that in the event that my insurance company, employer, or any other third party payer refuses to pay the rental and/or purchase price(s) of the above items, or delays payment beyond 90 days of my receipt of items, or in the event that I have no insurance coverage or third party payer, that I will be responsible for said payments and will make prompt reimbursement within 30 days of notification by **PEDIALIFT LLC** for all charges. THIS DOES NOT APPLY TO MEDICAID RECIPIENTS.

Medicare Recipients Only

I certify that I AM NOT receiving in home or facility based hospice care, skilled nursing care or hospital based care. I also understand that if the Medicare part B claim denies payment due to enrollment in the above listed types of care, I assume full responsibility for the cost of all equipment and services provided by **PEDIALIFT LLC.**

Cancellation Policy

Order cancellations after billing services have commenced and prior to shipment of the order, will incur a cancellation fee calculated as the greater of 10% of the invoiced amount of $750. Any claim payments received from the insurance provider(s) must be promptly returned to Forbes Rehab Services for claim cancellation.

I ACKNOWLEDGE AND UNDERSTAND THE ENTIRE CONTENTS OF THIS DOCUMENT AND REFERENCED DOCUMENTS.

_____	_____	_____
Client's Printed Name	Signature or Mark (X) of Client	Date

If the beneficiary is only able to sign by making a mark (X), a witness must enter his/her name and address below.

_____	_____
Printed Name of Witness	Address of Witness

If the beneficiary is physically or mentally unable to make a mark or signature, an authorized representative may sign on the beneficiary's behalf. In this case, the representative should print the beneficiary's name above and complete the following information, which we are required to have on file.

Signed for the beneficiary by: _____ _____

Signed & Printed Name of Representative — Address of Representative

Relationship to Beneficiary: _____ Reason Beneficiary cannot sign: _____ Date_____