WinCare, Inc.

PO Box 7276 Rocky Mount, NC 27804 800-850-0483

CLIENT AUTHORIZATION/ASSIGNMENT & SIGNATURE PAGE

1. AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize WinCare, Inc. to disclose any medical information currently existing or developed during the course of providing products and supplies from the client's record to (1) the referring physician or agency, including employees/agents thereof, and (2) any representative of: (a) any party financially responsible for the care, including Centers for Medicare and Medicaid Services, insurance companies, HMO's and self-insured employers (b) State agencies and (c) third-party billing companies engaged by WinCare. This authorization will allow any physician or any other person to have access to the client's records when needed to provide for care and services to the client. I understand that this consent is revocable except to the extent that action has been taken in reliance thereon.

I do consent to and authorize physicians and medical care agencies to disclose information about the client's health status to WinCare for the purpose of updating the client's records.

2. AUTHORIZATION OF PAYMENT

I authorize direct payment of medical benefits from Medicare and/or private insurance to WinCare. The benefits referred to herein would be payable to me if I did not make this assignment. I understand that I am personally responsible to WinCare for charges not covered by insurance, including charges for services and products determined to be non-medically necessary by a private insurer's utilization review program. If for any reason a personal check is returned there will be a $35.00 fee. I understand that I am financially responsible to WinCare Inc. for all co-payments, deductibles, and coinsurance.

I understand that WinCare reserves the right to review all agreements on an individual basis to determine the continued acceptance of assignment for Medicare and/or any other medical insurance companies. Please note: **You are responsible to sign over any payment made directly to you from your insurance company for supplies provided by WinCare.**

4. MEDICARE CERTIFICATION (when applicable):

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct.

3. ACKNOWLEDGEMENT OF RECEIPTS

I acknowledge receipt and understanding of my Client Rights and Responsibilities, Medicare DMEPOS Supplier Standards, and Notice of Privacy Practices that I received as part of my supply order.

I also acknowledge that I have received from WinCare and understand the plan of care (detailed written order), safe use of the products, contact information including on-call service, supplies and/or equipment including maintenance and warranty and home safety. In addition, I agree that WinCare may contact me in the future, via telephone, email, instant messaging, mail or other means of communication, regarding ordering medical supplies.

I UNDERSTAND AND AGREE TO ALL TERMS STATED ABOVE: (This is not a bill)

_____ _____

Customer Name (Printed) **Relationship**

_____ _____

Customer Signature **Date**

Reason client is unable to sign:_____