ASSIGNMENT OF BENEFITS / RELEASE OF INFORMATION
FOR THE USE AND DISCLOSURE OF MEDICAL INFORMATION

The following form must be completed to allow Hart Medical to submit claims on your behalf to your insurance company.

Customer Name: _____
Customer Address: _____
Customer email: _____

Items Ordered

Description:	Quantity:	Purchase or Rental:
Blue Glucose Monitor	1 each	N/A (Provided by Hygieia)
Lancing Device	1 each	Purchase
Control Solution	1 each	Purchase
Test Strips	Multiple	Purchase
Lancets	Multiple	Purchase

I hereby give consent to Hart Medical Equipment to use and disclose my protected health information for the purposes of treatment, payment, and health care operations. I request payment of authorized benefits to be made on my behalf to Hart Medical for any services / product provided to me.

By signing this agreement:

- I acknowledge that a printable electronic version of **Hart Medical's Notice of Health Information Privacy Practices** – which provides a detailed description of how Hart may use and disclose my health information – was made available to me at the time of transaction and is also available online at **hartmedical.org/welcomepacket**.
- I acknowledge I have received the equipment necessary to start my therapy, as detailed in the itemized work order I received with the equipment.
- I authorize Hart to release to my insurance company the necessary health care information for reimbursement and to start billing my insurance on the date this form is signed.
- I authorize Hart to obtain from any health care provider, medical information necessary for proper determination of benefits payable for related services.
- I accept financial responsibility and understand I am responsible for any charges not covered by my insurance company.
- I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished me by Hart Medical Equipment, including physician services. I authorize any holder of medical or other information about me to release to Center for Medicare & Medicaid Services and its agents any information needed to determine these benefits or benefits for related services.

Customer Signature: _____ **Date:** _____

IF CUSTOMER UNABLE TO SIGN, COMPLETE SECTION BELOW

By: Authorized Representative: _____ Relationship: _____
Representative Address: _____
Why Customer unable to sign: _____
If you have any questions regarding this form, please contact: 888-606-8778.