Hometown Medical Equipment

506 Manchester Expressway Suite B-13 Columbus, GA 31904

Phone: 706-507-2222 or 844-260-9280 / Fax: 706-507-2233

Website: http://www.htmeq.com/ Email: info@htmeq.com

Tricare preferred network provider
We proudly accept:
TRICARE

PHYSICIANS ORDER

Today's Date: _____

Patient's Full Name: _____ **D.O.B:** _____

Patient's Address: _____

Sponsor SSN w/Sponsor DOB OR Patient's Phone#:

Patient Benefit # w/Sponsor DOB: _____

Email Address: _____ **Due Date:** _____

Check all that apply:

	EQUIPMENT DESCRIPTION	ADDITIONAL INFO
☐	**DUAL ELECTRIC BREAST PUMP**	☐ AMEDA ☐ MEDELA ☐ LANSINOH ☐ SPECTRA S2 ☐ UNIMOM ☐ ZOMEE
☐	**POSITIONING PILLOW & WEDGE**	**Positioning Pillow & Wedge - proper alignment/comfort/pain relief**
☐	**COCCYX CUSHION**	**Pressure Relief Positioning Cushion - proper alignment/pain relief**
☐	**PELVIC SACRAL SUPPORT BELT**	**One size fits most**
☐	**ANTEPARTUM CARE STRUT SYSTEM** Prenatal System support for vagina pain, vulvar veins, edema, varicose veins	Depending on product selected patient will complete an electronic sizing form 1) Measuring for Antepartum & Postpartum Care Strut System measure under your belly, around the top of hips. 2) Antepartum System allow room for growth. Postpartum System allow room for swelling & shrinkage. 3) Maternity Support System requires three different areas to be measured
☐	**POSTPARTUM CARE STRUT SYSTEM** SIJ (Pelvic Sacral Support with double & single truss; which includes Abdominal Perineum Vaginal/Pelvic Floor Support with compression	
☐	**MATERNITY SUPPORT SYSTEM** SIJ (Pelvic Sacral Support belt with shoulder straps and groin straps to relieve abdominal and round ligament pain, hernia and hip discomfort.	
☐	**OTHER EQUIPMENT OR SUPPLIES:**	

(√) CHECK THE PATIENT TYPE, STYLE, AND QUANTITY NEEDED // PLEASE STATE HEIGHT & WEIGHT Height _____ Weight _____

☐KNEE LENGTH COMPRESSION HOSE 18-30 MMHG CLOSED TOE ONLY ☐QTY (_____) ***SHOE SIZE & CALF IRCUMFERENCE ***

☐NON MATERNITY COMPRESSION FULL LENGTH HOSE 18-30 MMHG ☐OPEN TOE ☐CLOSED TOE ☐QTY (_____) ☐MATERNITY COMPRESSION FULL LENGTH HOSE 18-30 MMHG ☐OPEN TOE ☐CLOSED TOE ☐QTY (_____)

Length of Need: _____ *(example: Lifetime or 99 months)*

Physician Name Printed:		**Phone #:**	
Physician Signature:		**Date:**	
Physician NPI:		**State:**	
Physician Address:		**MTF:**	

DIAGNOSIS:

☐ Z39.1 •Breastfeeding • Care of Lactating Mother

☐ 099.89 •Other specified conditions complicating pregnancy •Low Back Pain during pregnancy •Hip Pain •Pain Postpartum

☐ M53.3 •Sacrococcygeal Disorders •Coccydynia

☐ O22.42 •Hemorrhoids in pregnancy 2nd Trimester (12-55yrs)

☐ I83.813 •Varicose Veins Lower Extremities with pain

☐ O16.9 •Unspecified maternal hypertension, unspecified trimester

☐Other DX Please state:_____

☐ M79.606 • Unspecified Leg pain

☐ M54.5 •Low Back Pain

☐R10.2 •Pelvic and Perineal Pain

☐M54.30 •Sciatica Nerve Pain

☐N94.81 •Vulvodynia

☐R60.9 •Swelling, Edema

☐Other DX Please state:_____

NOTE: Please complete & fax to our office. Thanks

Hometown Medical Equipment

Tricare preferred network provider
We proudly accept:
TRICARE

_____ **Provision of Products:** I understand that my signature on this agreement authorizes HOMETOWN MEDICAL EQUIPMENT to provide to me the products and/or services listed on the FIRST PAGE of this form. I also understand that the products and/or services provided to me by HOMETOWN MEDICAL EQUIPMENT or its agents are provided under the direction of my healthcare provider. I further understand that HOMETOWN MEDICAL EQUIPMENT is not liable for any act or omission when following the instructions of my healthcare provider.

_____ **Sale Terms:**

a. FOR INEXPENSIVE OR ROUTINELY PURCHASED ITEMS: I understand and have been informed that equipment in this category will be purchased and the total amount paid cannot exceed the fee schedule purchase amount.

b. I agree that breastfeeding equipment will be used for single user usage & used for the purpose so indicated on the physician's prescription.

c. I agree to promptly notify HOMETOWN MEDICAL EQUIPMENT if my address changes or if I no longer need the supplies. I also agree to promptly notify HOMETOWN MEDICAL EQUIPMENT if there is a change in address.

d. I agree to notify the manufacturer as soon as possible of any equipment malfunction or defect. If issue is not resolved contact Hometown Medical Equipment for assistance. We agree to assist with the replacement or repair defective equipment in a timely manner from the manufacturer.

e. I agree due to personal nature of breastfeeding/maternity/postpartum equipment, supplies and parts; they are non-returnable & shall not be returned.

_____ **Release of Information to HOMETOWN MEDICAL EQUIPMENT:** I understand that my signature on this agreement authorizes any entity with medical information regarding me to release to HOMETOWN MEDICAL EQUIPMENT any information regarding my medical history, treatments or other relevant medical information, as it relates to equipment/services I am receiving from HOMETOWN MEDICAL EQUIPMENT.

_____ **Release of Information by HOMETOWN MEDICAL EQUIPMENT to insurance payers and other entities:** I understand that my signature on this agreement authorizes HOMETOWN MEDICAL EQUIPMENT to release my HOMETOWN MEDICAL EQUIPMENT medical records to:

a. Any authorized insurance representative of my insurance carrier or my workers comp company or my attorney for use in determining benefits.

b. Any authorized representative of certain local, state or national licensing, credentialing or accrediting boards or bodies.

c. Certain local, state and national entities as well as certain public utilities for Emergency Preparedness planning purposes.

d. Other providers of clinical care involved in my medical care.

e. I understand that, prior to signing this document; I have a right to review the "Notice of Privacy Practices for Protected Health Information" which is located on Hometown Medical Equipment website https://www.htmeq.com which will provide me details & a more complete description of the uses and disclosures of health information by HOMETOWN MEDICAL EQUIPMENT. I further understand that HOMETOWN MEDICAL EQUIPMENT reserves the right to change its privacy practices as described in the "Notice of Privacy Practices for Protected Health Information," and that if HOMETOWN MEDICAL EQUIPMENT exercises that right, a revised notice may be obtained by contacting the person designated in the "Notice of Privacy Practices for Protected Health Information." A copy of the HIPAA policy will be enclosed with the equipment listed on the FIRST PAGE, along with a copy of this agreement.

This release specifically includes the release of my medical records. I understand that I have the right to refuse to release my medical records and that by signing this agreement, I waive that right. This consent is valid for whatever time period is reasonably necessary for these authorized representatives to complete the tasks and shall remain in effect until such time as I revoke it in writing. The revocation will have a prospective application only.

_____ **Assignment of Insurance Benefits:** I request that payment of all insurance benefits, including any OHI or supplement carrier, if I have additional coverage benefits to be made on my behalf to Hometown Medical Equipment for durable medical equipment and supplies ordered by my healthcare provider. I authorize any holder of medical information about me to release to the insurance carriers(s), workers comp, attorney, or any other entity 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 HCFA-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 Workers' Comp cases, the supplier agrees to accept the charge of determination of the Workers Comp carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non covered items. All Patient's Coinsurance and the Deductible are based upon the charge determination of the insurance carrier.

_____ **Acknowledgement of My Financial Responsibility:** I understand that my insurance coverage may not pay the total cost of the products or services provided to me by HOMETOWN MEDICAL EQUIPMENT Including Workers' Comp assigned claims; this means that I am responsible for deductibles and coinsurance amounts required by these programs. I understand that I must pay the balance between what my insurance coverage will pay and what HOMETOWN MEDICAL EQUIPMENT can charge for these services and products. I further acknowledge that I will be responsible and pay within 60 days from the date that the claim was submitted to my insurance payer for the full amount of charges associated with any products or services I receive from HOMETOWN MEDICAL EQUIPMENT should my insurance payer deny payment for any reason (including, but not limited to, my failure to qualify for the products or services, non-coverage by my insurance payer, or my failure to provide complete and accurate information to HOMETOWN MEDICAL EQUIPMENT necessary for billing my insurance payer.) I agree to remit to HOMETOWN MEDICAL EQUIPMENT any payments made directly to me by my insurance payer for products or services provided by HOMETOWN MEDICAL EQUIPMENT on an assigned basis. I agree to be responsible for my co-payments and annual deductible amounts.

_____ **Supply Shipment:** I agree to have supplies shipped directly and agree to the following supply policy: Standard monthly supply will ship to my home monthly or quarterly depending on the supply type. Please refer to your insurance carrier for what your supply limits are. If I require supplies not considered standard by my insurance carrier, I must contact my provider for a prescription written specifically for that & list the exact amount that is required. Each time a new prescription must be written by my provider. Any questions or concerns regarding NON-STANDARD supplies, please contact your insurance carrier. Furthermore, I understand for any changes to my shipment, ***I must contact HTME via email (RX@Htmeq.com) or HTME website "Contact Us" form prior to the 20th of the month.*** However, if there is an insurance change/address change I will utilize the same contact method **IMMEDIATELY**.

_____ I have not received this equipment from any other provider & attest all information provided is true

I have received written & oral orientation for safe use & maintenance of the products provided by HOMETOWN MEDICAL EQUIPMENT. by signing below I certify that: (i) I have read this form; (ii) I will receive a copy of this form with my equipment shipment; and (iii) I am the patient or a person duly authorized by the patient to lawfully execute this form and accept its terms on the patient's behalf.

Patient Name (Printed):_____ **DOB:** _____

Patient/Representative Signature:_____ **Date:** _____

Relationship to Patient:_____ **Patient's Phone # :(____)** _____

Hometown Medical Employee Signature & Date: _____

506 Manchester Expwy Suite B13 • Columbus GA 31904
OFFICE #: (844) 260-9280 or (706) 507-2222 • FAX #: (706) 507-2233 • Website: https://www.htmeq.com • Email: info@htmeq.com

ATTENTION PATIENT: Please complete this entire form