

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](mailto:info@htmeq.com)

## PHYSICIANS ORDER

Patient's Full Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
 Patient's Address: \_\_\_\_\_ D.O.B: \_\_\_\_\_  
 Sponsor's SSN or Patient Benefit #: \_\_\_\_\_ Patient's Phone#: \_\_\_\_\_  
 Email Address: \_\_\_\_\_ Due Date: \_\_\_\_\_

Check all that apply:

	EQUIPMENT DESCRIPTION	ADDITIONAL INFO
<input type="checkbox"/>	E0603 Standard Dual Electric Breast Pump	<input type="checkbox"/> Medela <input type="checkbox"/> Spectra <input type="checkbox"/> Ameda <input type="checkbox"/> Lansinoh
<input type="checkbox"/>	A9999 Breast Pump Kit or Supplies	<input type="checkbox"/> breast shield size if known:
<input type="checkbox"/>	PELVIC SACRAL SUPPORT BELT	One size fits most
<input type="checkbox"/>	COCCYX CUSHION	Positioning Cushion to provide comfort & proper alignment for pain relief while patient is sitting
<input type="checkbox"/>	POSITIONING PILLOW WEDGE COMBO	Therapeutic Positioning Pillow Wedge Combination Unit for proper alignment, comfort & pain relief
<input type="checkbox"/>	<b>Postpartum Care Strut System</b> Sacroiliac Orthosis, Pelvic Sacral Support w/Straps Brace; which includes Abdominal Perineum Pelvic Floor Support. Triple Truss design with Compression and Vaginal Support  1) How to measure for the postpartum care strut system? It is sized to fit the postpartum body and has over 6" of adjustability to shrink with patient as they heal. 2) When sizing, we recommend measure the top of the patient's hip bone (Iliac Crest) for sizing Please state the patient measurement: _____	PLEASE PLACE A (√) CHECK NEXT TO THE SIZE NEEDED FOR THE PATIENT (we will call patient before shipment) _____ X-Small (26" - 32")                      _____ X-Large (42" - 48") _____ Small (32" - 37")                      _____ 2X-Large (48" - 54") _____ Medium (35" - 42")                      _____ 3X-Large (54" - 60") _____ Large (38" - 45")                      _____ 4X-Large (60" - 64")
<input type="checkbox"/>	OTHER EQUIPMENT OR SUPPLIES NEEDED: (Please specify what's needed)	

Length of Need: \_\_\_\_\_ (example: Lifetime or 99 months)

Physician Name Printed:	Phone #:	
Physician Signature:	Date:	
Physician NPI:	State:	
Physician Address:	MTF CLINIC Private Practice Circle Type & Enter Name	

**DIAGNOSIS:**

- |  |  |
|--|--|
| <input type="checkbox"/> Z39.1 •Breastfeeding / Normal Breastfeeding                           | <input type="checkbox"/> M54.5 •Low Back Pain            |
| <input type="checkbox"/> M53.3 •Sacrococcygeal Disorders •Coccydynia                           | <input type="checkbox"/> R10.2 •Pelvic and Perineal Pain |
| <input type="checkbox"/> O22.42 •Hemorrhoids in pregnancy 2 <sup>nd</sup> Trimester (12-55yrs) | <input type="checkbox"/> M54.3 •Sciatica Nerve Pain      |
| <input type="checkbox"/> O99.89 •Other specified conditions complicating pregnancy             | <input type="checkbox"/> N94.81 •Vulvodinia              |
| <input type="checkbox"/> O99.89 •Low Back Pain during pregnancy •Hip Pain •Pain Postpartum     |  |
| <input type="checkbox"/> Other DX Please state: _____  | <input type="checkbox"/> Other DX Please state: _____    |

**NOTE: Please complete & fax to our office. Thanks**

**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.

**Orientation:** I have received written & oral orientation for safe use & maintenance of the products provided by HOMETOWN MEDICAL EQUIPMENT

**Supply Shipment:** I agree to have my supplies sent directly via shipment and agree to the following supply policy: Standard monthly supply will ship to my home monthly: Breastshields (2), Storage bags (200), Collection/Storage Bottles (2). We understand each mom is different with her breastfeeding & supply need varies. If I have more than a 14 day supply on hand, then I'm to contact HTME via the methods listed below to stop or hold my shipment prior the 20th of the upcoming month. Furthermore, I understand I must contact HTME via email (RX@Htmeq.com) or HTME website "Contact Us" form prior to the 20th of the month. If I require more supplies, fewer supplies, place my shipment on hold, stop my shipment stopped or change my supply qty OR if I need to change my address I will use the same method of contact.

I have not received this equipment from any other provider & attest all information provided is true (Initials) \_\_\_\_\_

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: \_\_\_\_\_

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**ATTENTION PATIENT: Please complete this entire form**