



HIPAA DOCUMENT

I hereby give my consent to the equipment manufacturer, physician, facility and their representatives to disclose to Mediplant Funding, Inc (hereafter referred to as the supplier) and its representatives, information about me for example: SSN, Insurance information, Medical information such as: physician notes, mental health information (psychological evaluations), and reports, as is reasonably necessary to verify my insurance coverage, review my clinical information, conduct precertification, predetermination or appeals on my behalf, provide customer service support or provide products and/or devices to be used in your diagnosis and treatment.

Once my health information has been disclosed to Supplier, federal privacy laws may no longer protect the information. Supplier agrees to protect this information by using and disclosing it only for the purposes described above or as required by law. Supplier will not further use or disclose my health information unless information that identifies me directly; such as my name or social security number, is first removed. These limitations continue even after the expiration or revocation of the authorization.

Assignment of Insurance Benefits: I hereby authorize payment to be made directly to Mediplant Funding, Inc for any devices provided, ordered by my physician, from any insurance, healthcare benefits or other payor, otherwise payable to me. I understand there is no guarantee of payment from any insurance company or other payor and agree that I am financially responsible for all charges associated with co-payments, deductibles or other coinsurance per allowed amounts, by any insurance company or other payor within a time period the Supplier deems reasonable. I also agree that in the event that my insurance company issues payment directly to me for services rendered I will in turn, endorse and forward the full payment amount to the supplier in exchange for supplies utilized during my treatment.

Assignment of Claims: I hereby assign to the Supplier that provides Devices ordered by my physician any and all claims and causes of actions against an insurance company or any payor for payment for the Supplier's devices provided to me. I understand and agree that this assignment takes effect upon notice to me by the Supplier that it intends to exercise these rights. I also understand that this assignment is given to permit the Supplier to pursue these claims on my behalf as a courtesy to me and that the Supplier is not required to exercise these rights and may do so in its sole discretion without any liability for its decision. I also agree that this assignment does not in any way affect my obligations and agreement to pay the Supplier's charges (not to exceed any co-payments, deductibles or other coinsurance per allowed amounts) for Devices provided to me.

I understand that:

- I may refuse to sign this document, but if I refuse Supplier will not be able to verify my Insurance coverage, review my clinical information, conduct precertification/ predetermination on my behalf, assist and/ or conduct appeals and provide customer support or provide products and/or devices.
- My Healthcare Provider and Health Insurance plan will not condition my medical treatment, payment for treatment, insurance enrollment or eligibility for insurance benefits on my agreement to sign this document.
- I may revoke this authorization by mailing or faxing a signed letter of revocation to Mediplant Funding, Inc. If I revoke this authorization, Supplier will be unable to assist my healthcare provider in obtaining payment for prescribed procedures and devices.
- Revoking this authorization will prohibit disclosures of information that identifies me after the date my letter of revocation is received and processed by my Health Care Provider and Health Insurance Plan but will not affect Suppliers ability to use and disclose the information they have already received from my Health Care Provider and Health Insurance plan.

Patient or Legal Representative: _____

Date: _____

Print Name: _____

Relationship to Patient: _____