Comfort Care Medical Equipment
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Order Consent Form

1. Insurance Coverage & Financial Obligation. As a courtesy to you, Comfort Care Medical verifies your insurance coverage before processing an order or submitting any claim; however, verifying coverage under your plan remains your responsibility, and we strongly encourage you to confirm your benefits. Any financial obligation will be clearly explained to you. Patients are responsible for all amounts deemed their responsibility by their insurance plan, including copays, deductibles, coinsurance, and non-covered services. Coinsurance and deductibles vary by policy, and we can only approximate the percentage covered by each plan. Payment of the estimated portion is due at the time of service, before Comfort Care processes the order. If we have overestimated your fees, the excess will be remitted to you; if we have underestimated, we anticipate prompt payment of the balance. Comfort Care Medical will manage all appeals and denials on your behalf, allowing you to concentrate on your health and well-being. **Interest-free payment plans are available.**

2. Communication Consent. I authorize Comfort Care Medical to contact me by phone, voicemail, text message, or email regarding my orders, account, billing, documentation requests, insurance requirements, and related services, using contact information provided by me or supplied through my referring provider or healthcare facility. I understand that standard text messaging and unencrypted email may not be fully secure methods of communication, and by signing this consent I acknowledge and accept this risk. I may request encrypted email or phone-only contact at any time, and I may withdraw consent for text or email communication at any time by notifying Comfort Care Medical in writing. Revocation will not affect prior communications but may impact the timeliness of updates regarding my order or insurance processing.

3. Order Consent / Assignment of Benefits. I authorize Comfort Care Medical to fulfill the order of the device prescribed by my physician and to bill my insurance company, and I authorize my insurance company to release payment of all monies to Comfort Care Medical to satisfy the total billed amount for all services. I agree to accept the item(s) when notified by Comfort Care Medical that the order has been fulfilled. I understand that Comfort Care Medical will verify insurance and request authorization from my insurance company as a courtesy; however, I acknowledge that insurance verification and authorization do not guarantee payment. In the event a claim is denied and any appeal is unsuccessful due to factors outside of Comfort Care Medical's control — including inaccurate or incomplete information provided by myself, failure to return a required Proof of Delivery (POD), or failure to disclose hospice care or residence in a nursing or institutional facility — I understand that I may be financially responsible for the cost of the garment. If credit terms have been provided, I agree to pay the total amount on the invoice within the terms on file with Comfort Care Medical.

4. Notice of Privacy Practices & Authorization for Release of Medical Records. Comfort Care Medical has provided me with its Notice of Privacy Practices, and I understand how my protected health information (PHI) will be used in connection with obtaining medical products and services. By signing this consent, I authorize my physician(s), therapist(s), clinician(s), healthcare facilities, and any other treating providers to release and disclose to Comfort Care Medical any medical records necessary to process my order, including but not limited to prescriptions, physician notes, progress notes, evaluations, diagnostic information, and documentation supporting medical necessity. I understand that Comfort Care Medical may use and disclose my medical information for treatment, payment, and healthcare operations, and for other purposes permitted or required by law; that certain PHI is required to bill my insurance company; and that only the minimum necessary information for billing and compliance purposes will be disclosed. Comfort Care Medical is a healthcare provider and complies with all applicable HIPAA regulations governing the use and protection of PHI.

5. Proof of Delivery & Date of Service. After I receive my items, insurance requires a signed Delivery Ticket (Proof of Delivery) before any claim can be submitted for coverage; my signature confirms to my insurance company that I received the items ordered. **I understand that the date I sign the Delivery Ticket becomes the official date of service reported to insurance,** which may impact my deductible or out-of-pocket responsibility if my benefits reset before it is signed. Timely signature helps ensure proper benefit application and avoids unnecessary delays or unexpected financial responsibility.

6. Warranty Information. Comfort Care Medical honors all warranties under applicable state law and manufacturer terms. If any Medicare-covered item or component fails during the manufacturer's warranty period, Comfort Care Medical will repair or replace the item at no cost to you, and you will not be billed for warranty-covered repairs or replacements. Once the garment has been received by Comfort Care Medical from the vendor, you have 30 days to be fit with the garment; noncompliance may affect the manufacturer's warranty coverage. Per vendor regulations, a replacement garment can only be provided when an incorrect size was issued based on measurements taken on the date of service. Although an item may be difficult to put on, take off, or may feel uncomfortable, vendor regulations may limit returns; however, Comfort Care Medical will remeasure you to verify sizing and exchange when appropriate. Your signature below acknowledges that you have been instructed on the use, wear, and warranty of prescribed products, and that you understand Comfort Care Medical will honor all applicable warranties in compliance with Medicare requirements.

_____	_____	_____
Patient Name	**Signature**	**Date**
_____	_____	_____
Legal Rep Name (If Applicable)	**Signature**	**Date**