Patient Consent Form for Home Medical Equipment

dermitech PHOTOTHERAPY

Please fax to 214-414-2533, email to sales@dermitech.com, or mail to PO Box 801403, Dallas, TX 75380-1403

To be filled out by the patient and sent to Dermitech. For assistance, please call 214-377-8144.

Patient Information

Patient Name_____ Cell Phone_____

Address_____ Alternate Phone_____

City_____ State_____ Zip _____ Date of Birth_____

Email_____ Physician_____

Diagnosis: ☐ Psoriasis ☐ Vitiligo ☐ Eczema ☐ Other_____

I prefer to be contacted by: ☐ Email ☐ Phone (voice) ☐ Text

Insurance

Verify Health Insurance Benefits?

No ☐ **Please contact me to discuss only self-pay options**

Yes ☐ **I wish to have Dermitech Phototherapy verify insurance benefits and contact me to discuss options. I authorize the following:**

1. Assignment of Medicare, Medicaid, Medicare Supplemental or other insurance benefits to Dermitech Phototherapy, its suppliers or order fulfilling partners. 2. Direct billing to Medicare, Medicaid, Medicare Supplemental or other insurer(s). 3. Release of my medical information to Medicare, Medicaid, Medicare Supplemental or other insurers and their agents and assigns. 4. Dermitech Phototherapy or order fulfilling partners to obtain medical or other information necessary in order to process my claim(s), including determining eligibility and seeking reimbursement for medical equipment provided.

Confirmation

I confirm that the above information is accurate and complete to the best of my knowledge. I authorize Dermitech Phototherapy or its suppliers or order fulfilling partners to contact me by phone, email, postal mail or text regarding my medical equipment order. I authorize any holder of medical information about me to release to Dermitech, my physician(s), caregiver, CMS or its agents.

☐ ✓ Check Here

I have read and understand Dermitech Phototherapy's disclosure document that includes the HIPAA Privacy Policy, Scope of Services, Patient Responsibilities, Patient Rights, Warranty Coverage, and Problems/Complaints.

Signature _____ **Date** _____

Relationship to Patient: ☐ **Self** ☐ **Parent (patient is under 18)** ☐ **Authorized Representative**

If Parent or Authorized Rep., please print name _____

If Authorized Rep., reason patient can't sign _____