LIFETIME RELEASE AND ASSIGNMENT OF BENEFITS (USA)

ABN / RELEASE FORM

Client First Name	Client Last Name	DOB (MM/DD/YYYY)	State of Residence

I authorize the release of any medical or other information necessary for determining benefits payable for equipment or services and processing claims by the Center for Medicare & Medicaid Services, my insurance carrier and any other medical/insurance entity including insurance claim processors employed by Control Bionics I understand that on occasion, funding or reimbursement barriers are encountered. I hereby authorize, if necessary, Control Bionics to release information related to my claim for funding to the Disability Law Center.

I authorize payment of insurance benefits, including Medicare if applicable, be made either to me or on my behalf to Control Bionics for any equipment or services provided to me. Should I receive payment directly from an insurance company, I agree to endorse and forward the check and "Explanation of Benefits" to Control Bionics within seven (7) days of receipt to: **Control Bionics 745 Center Street, Ste 303 Milford, OH 45150**

I understand that failure to provide this information will result in myself being held legally responsible for payment in full for all equipment or services which I have been provided by Control Bionics.

I understand that I am financially responsible to Control Bionics for any charges not covered by health care benefits. I agree to notify Control Bionics of any changes made in my health care insurance coverage. In some cases, exact insurance benefits cannot be determined until the insurance company received the claim. I understand that I am responsible for the entire bill or balance of the bill as determined by Control Bionics and/or my health care insurer if the submitted claims, or any part of them, are denied for payment.

I understand that by signing this form, I am accepting financial responsibility as explained above for all payment for products received. This does not apply when Medicare determines the balance to be the contractor's obligation.

I have read and understand Control Bionics' Patient Bill of Rights and Responsibilities, the Control Bionics DMEPOS Supplier Standards, the Control Bionics Notice of Privacy Practices, and the Control Bionics 30 Day Return Policy.

This form must be signed and dated to be valid. Mark is acceptable with witness. Please submit this completed form via email, fax, or mail to:

FUNDING@CONTROLBIONICS.COM
F: (513) 322-4678

CONTROL BIONICS
Attn: Funding
745 Center St, Suite 303
Milford OH 45150

Questions? Email funding@controlbionics.com

Signature				Date (MM/DD/YYYY)
Signer Relationship to Client	☐ Self	☐ Legal Guardian	☐ Power of Attorney	☐ Spouse
Witness Signature				Date
Witness First Name	Witness Last Name			
Witness Relationship to Client	☐ Family	☐ Friend	☐ Support Professional	

LIFETIME RELEASE / ASSIGNMENT OF BENEFITS / PAYMENT AGREEMENT (USA)

LINCARE ABN / RELEASE FORM

Customer ID (Internal Use Only)

Patient Name	DOB (MM/DD/YYYY)	State of Residence

I authorize the release of any medical or other information necessary for determining benefits payable for equipment or services and processing claims by the Centers for Medicare and Medicaid Services, my insurance carrier, and any other medical/insurance entity. I understand that on occasion, funding or reimbursement barriers are encountered.

I authorize payment of my insurance benefits be made either to me or on my behalf to Lincare AAC® for any equipment or services provided to me. In certain circumstances, my insurance company may send a check for services provided by Lincare AAC directly to me. I agree to endorse and forward the check and "Explanation of Benefits" within five days of receipt.

If I fail to provide this information, I understand that I will be held legally responsible for payment in full for all equipment or services which have been provided by Lincare AAC.

I understand that I am financially responsible to Lincare AAC for any charges not covered by healthcare benefits. I agree to notify Lincare AAC of any changes in my healthcare insurance coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I understand that I am responsible for the entire bill or balance of the bill as determined by Lincare AAC and/or my healthcare insurer if the submitted claims or any part of them are denied for payment.

I understand that by signing this form, I am accepting financial responsibility as explained above for all payment for products received. This does not apply when Medicare determines the balance to be the contractor's obligation, or to Medicaid recipients.

I have read and understand the Lincare AAC 30-day return policy and the Patient Bill of Rights and Responsibilities (which includes the process to file a grievance or complaint with the Company, the Lincare AAC DMEPOS supplier standards, and the Lincare AAC notice of privacy practices).

This form must be signed and dated to be valid. Mark is acceptable with witness. Please submit this completed form via email, fax, or mail to:

FUNDING@CONTROLBIONICS.COM
F: (513) 322-4678

CONTROL BIONICS
Attn: Funding
745 Center St, Suite 303
Milford OH 45150

Questions? Email funding@controlbionics.com

Signature (Client, Parent, Legal Guardian, Power of Attorney, or Legal Representative)	Date (MM/DD/YYYY)

Signer Name	Relationship to Client

LIFETIME RELEASE / ASSIGNMENT OF BENEFITS / PAYMENT AGREEMENT (USA)

NUMOTION ABN / RELEASE FORM

Customer Name	DOB (MM/DD/YYYY)	State of Residence
Equipment		

_____ **Mission, customer information, customer complaints, customer rights and responsibilities, and accreditation information (see Customer Handbook).**

_____ **Acceptance of Services** – I understand by signing this agreement I authorize provision of products and/or services to me by Numotion. I also understand that the products and services provided are prescribed by my physician and that it is necessary that I remain under the supervision of my attending physician during the course of my care.

_____ **Medical Information Authorization** – I hereby authorize release to Numotion any, and all, of my medical records pertaining to my medical history, services rendered or treatments received from my physician(s), hospital or nursing agencies. In order to process insurance claims, I also hereby authorize Numotion to furnish to my insurance carriers, or school, any medical history, services rendered or treatment needed. I also understand that my information may be subject to review by credentialing, accreditation or governmental agencies.

_____ **Assignment of Insurance Benefits** – I authorize direct payment of insurance benefits by my insurance company to Numotion. In the event that my insurance carrier does not accept "assignment of benefits," I understand that payments may be sent directly to me and that I am obligated to endorse and directly send such payments to Numotion for payment of my bill. I understand that I am obligated to report any changes in insurance coverage promptly to Numotion.

_____ **Financial Responsibility** – I understand that I am responsible to Numotion for all charges not covered by my insurance. I recognize that in the event that my insurance company, employer or any other third party payor refuses to pay the rental and/or purchase price(s) of the above items, or delays payment beyond 90 days of my receipt of items, or in the event that I have no insurance coverage or third party payor, that I will be responsible for said payments and will make prompt reimbursement within 30 days of notification on by Numotion on for all charges.

_____ **If you have Medicaid** – I understand that if I have Medicaid I am not financially responsible for covered items as long as my Medicaid number is active at the time of delivery. I further understand that I may/will be responsible for charges if my Medicaid status changes. I will notify Numotion of any changes in my Medicaid coverage.

_____ **Return Policy** – The equipment Numotion sells is custom/specialized or ordered special and is not returnable. I authorize Numotion to send email order status updates to me, my caregiver and / or my clinician.

_____ **Photographic Release** – I hereby grant permission to Numotion to take photographs/video which may be used to document medical necessity for equipment or services provided by Numotion, and which may be submitted to insurance payors or other medical professionals as needed for evaluation on and/or consultation. I hereby release Numotion from any liability associated with these photographs/videos so long as they are used for the purposes as described above.

This form must be signed and dated to be valid. Mark is acceptable with witness. Please submit this completed form via email, fax, or mail to:

FUNDING@CONTROLBIONICS.COM
F: (513) 322-4678

CONTROL BIONICS
Attn: Funding
745 Center St, Suite 303
Milford OH 45150

Questions? Email funding@controlbionics.com

Signature	Date (MM/DD/YYYY)
Signer Name	Relationship to Customer
Signer Address	
Numotion Representative	Date (MM/DD/YYYY)

numotion™ Mobility starts here.

CALL US AT (888) 546-8595 WITH ANY QUESTIONS