

**Assignment of Benefits
Statement of Confidentiality
Patient Responsibility**

Words +, Inc

Beneficiary/Client Name _____

Assignment of Benefits

I request that payment of the above named insurance/s benefits be made to Words+, Inc. on my behalf for any equipment or services furnished to me by that supplier. I authorize any holder of medical information about me to release to the necessary insurance carrier, their intermediaries, or agents any information needed to determine these benefits or the benefits payable for related services. **Please initial** x _____

Statement of Confidentiality

I authorize the release of necessary medical information to Words+, Inc. for the purpose of processing this or any related claim. I also authorize Words+, Inc. to release requested documentation for this claim or any related claim to myself and/or other health care providers involved in the treatment of my condition. **Please initial** x _____

Patient Responsibility

I accept responsibility for payment of any balance due on equipment or services supplied to me by Words+, Inc. I understand that I am not relieved of my financial responsibility in the event that my above mentioned insurance carrier/s does not pay the entire billed amount. *Words+, Inc. will notify you of any co-payment that is due prior to the delivery of the equipment requested. All co-payments, deductibles, and out of pocket expenses must be paid prior to the delivery of any equipment.* **Please initial** x _____

Notice of Privacy Practices

Words+, Inc. may use and disclose your protected health information in order to carry out treatment, payment and healthcare operations and for other purposes permitted or required by law. Words+, Inc. will provide you access to your rights that control your personal health information. Personal Health Information is individually identifiable information relating to your health, to the care provided to you or to payment of health care. *A copy of your rights will be delivered with your order or you can review a copy of your rights on our website at www.words-plus.com*

Please initial x _____

My signature below indicates that I agree with the above terms and conditions and acknowledge the Notice of Privacy Practices stated by Words+, Inc.

Signature of Client _____ **Date** _____ *

If Client is unable to sign

Sign client full name _____ Representative signature _____

Relationship to client _____ Representative Name _____

Representative Address _____ City _____ State _____ Zip _____

Reason client unable to sign _____ **Date** _____ *

*** Form must have an original signature with the date**