Patient Agreement

Today's Date : _____

Patient's Name _____ SS# _____

Address _____ City/State/Zip _____

Request for Provision of Services

I understand that by signing this agreement, I indicate my wish to contract health care services from Wellness Medical Supply. during the entire period of my therapy.

Indication of Medical Responsibility

I understand that I am in the supervision and control of my attending physician. I also understand that my physician has prescribed the therapy noted as part of my treatment. I understand the Wellness Medical Supply. does not include diagnostic, prescriptive or other functions typical performed by licensed physicians, and that my physician is solely responsible for diagnosing, prescribing drugs and therapy for my condition and otherwise supervising and controlling my medical care.

Agreement to Pay

In consideration of Wellness Medical Supply. willingness to undertake the supplying the patient with any products and services ordered by the patient or on behalf of the patient, the undersigned patient, spouse, guarantor ad/or guardian agrees that each of them is responsible for the payment to Wellness Medical Supply. for all such products and services provided to the patient.

Assignment of Benefits

The patient hereby assigns to Wellness Medical Supply. the benefits of any and all insurance policies covering myself and my illness, for the services, supplies and equipment rendered and to be rendered. In the event that payment for insurance benefits is made directly to the undersigned, the payee will endorse all checks for such payments and forward them to Wellness Medical Supply within five (5) days of receipt. In the event that it is necessary for Wellness Medical Supply. to incur additional collection expenses, including to attorney fees, the additional expenses become the responsibility of the patient, who agrees to be held responsible for such expenses.

Release of Information

The undersigned authorizes our insurer(s) and any other third party payor who provides patient(s) with coverage to disclose to Wellness Medical Supply. any information regarding such coverage, including but not limited to A) Payments made by such insurer(s) or third party payor(s) to any of us, for therapy rendered to the patient by Wellness Medical Supply. and B) the scope and extent of coverage available from time to time.

The patient also authorizes all medical personnel to provide information to Wellness Medical Supply. pertaining to his/her medical history, as it may relate to the patient's home therapy.

The undersigned consents to the review of his/her records including medical records by any Federal, State or Accrediting Body or Agency as required by the Regulating, Licensing or Accrediting Body.

Note: A duplicate copy of this Agreement and Consent shall be considered the same as original.

The undersigned certifies that he/she has read the above information. Furthermore, the undersigned also certifies that he/she is the patient, or is dully authorized by the patient, as the patient's general to execute this agreement and accept its terms.

_____ _____

Signature of Patient or Legal Guardian / Date

Signature of Representative from WMS / Date