NATIONAL SEATING & MOBILITY

Consent for Purposes of Provision of Products, Services, Payment & Assignment of Benefits

Client's Name: Anthony Scott Bachmeier

Medicare-HICN (and/or other health insurance number): 71304668600

I consent to the use or disclosure of my protected health information by National Seating and Mobility, Inc. (NSM) for the purpose of evaluating my needs; providing products and services to me; and obtaining payment for those products and services. I understand that the provision of products and services to me by NSM may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out evaluation, provision of products and services, and payment. NSM is not required to agree to the restrictions that I may request. However, if NSM agrees to a restriction that I request, the restriction is binding on NSM and all its employees. I have the right to revoke this consent, in writing, at any time, except to the extent that NSM has taken action in reliance on this consent. My "protected health information" means health information, including my demographic information, collected from me and created or received from my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review NSM's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in the provision of products and services and payment of my bills. This Notice of Privacy Practices also describes my rights and NSM's duties with respect to my protected health information. The NSM Notice of Privacy Practices has been made available to me and is also posted in the lobby area of the local NSM branch office and on NSM's website at www.nsm-seating.com. NSM reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by accessing NSM's website, calling the office and requesting a revised copy be sent in the mail, or asking for one at the time of my next appointment.

I have been advised of and understand the Client Rights and Responsibilities as they relate to the provision of this equipment and have received a written copy. I have also received a copy of and understand the Medicare Supplier Standards.

Client name: (please print) Anthony Scott Bachmeier

Client or Authorized representative's signature: _____ Date: _____

Authorized representative's name: (please print) _____ Relationship to client: _____

Assignment of benefits - I hereby authorize that payment of my Medicare, Medicaid, or other insurance benefits to cover the following products and services be made, on my behalf, to NSM. (general product(s) description): cushion

Unassigned Medicare Claim - If NSM and I agree that the equipment be provided as an unassigned Medicare claim, I understand that I will be responsible for paying for the equipment, in full, at the time of delivery.

Financial responsibility - I understand that I will be responsible for any deductible or co-insurance. I further understand that I will be responsible for payment in the event my insurance carrier denies payment. I understand that I will be responsible for any interest charges, collection or attorney's fees in the event my balance owed to National Seating and Mobility, Inc. becomes 60 days past due. If the equipment provided is covered by Medicare, I will be responsible for the co-payment only, unless I sign an Advanced Beneficiary Notification of Medicare Non-payment.

Medicaid Coverage - I further understand that if, at the time of delivery and billing for the equipment, I am covered, eligible, and participating in a Medicaid program and this has been disclosed to National Seating and Mobility, Inc., I will not be responsible for any payment.

By my signature below, I acknowledge that I have read, understand, and agree to the foregoing provisions. If I am not the client, my signature acknowledges the same and that I am duly authorized by the client or by law as the client's agent and/or representative to execute the document on the client's behalf.

Client name: (please print) Anthony Scott Bachmeier

Client signature: _____ Date: _____

Authorized representative (or witness) name: (please print) _____

Authorized representative (or witness) signature: _____ Date: _____

Authorized representative address: _____

Relationship to client: _____

Reason client cannot sign: _____