Patient's Release

This agreement is between the patient and GTH Complete Injury Care "HOMA DME PC" (the company)

☐ (check box) The Company is the supplier. I understand that the equipment is to be used only for my diagnosed condition and will be issued under a doctor's prescription. I have read and/or viewed (when available) the product(s) instructions (refer to website instruction page) and understand the use of the equipment, and I am aware of the warnings/precautions. I also understand the company and/or my doctor may give me additional product instructions. I absolve the company, responsibility in the event of any accident or injury from the use of this equipment.

☐ (check box) I authorize the company to provide supplies for this equipment as prescribed by my doctor. Should my supplies become over or under stock, I understand that it is my responsibility to contact the company.

☐ (check box) I understand the following items are available in patient resources/ product description/company product: Rights & Responsibilities, Service availability of company, Privacy notice, Medicare supply standards, cleaning and maintenance of equipment, equipment instructions, complaint process, and warranty information. I have read and/or been instructed in detail on the above items. I understand the above items and should I have any additional questions I should contact the company

☐ (check box) I hereby authorize and request my auto insurance company and/or my worker's comp insurance carrier and/or my private insurance carrier and/or attorney to pay directly to the company such sums that maybe due for any medical equipment/supplies and/or medical services rendered. In the event that my insurance company has a preferred provider that is considered in network, I instruct my insurance company to apply my out of network benefits. I hereby further give a lien on my worker's comp or auto case to the company, against any and all proceeds of any settlement, judgement, or verdict that may be paid to me or to my attorney.

☐ (check box) I authorize any holder of medical information about me to release to the company, my physician(s), caregiver, CMS, its agents and to my primary and/or medical insurer any information needed to determine or secure eligibility information and/or reimbursement for covered services.

By my signature below, I acknowledge that I have read, understand, and agree with the statements contained above. I have also read and understand the product instruction(s) and may receive additional specific instructions from the company and/or my physician.

Print and Mail/Fax to: GTH Complete Injury Care 200 E Arch St, Pottsville, Pa 17901 / Fax: 570-628-5080