Soundview
Medical Supplies for Senior Care

Assignment of Benefits

Customer Name:

Facility Name:

Street Address:

I authorize contact from this office to confirm my orders & billing information via:

Customer Contact Phone: Alternate Phone:

Please list any other parties who can have access to your health information
(This includes relatives & any professional care takers who can have access to this patient's records.)

Name: Relationship:

Name: Relationship:

Please list all insurance policies below

Insurance: ID:

Insurance: ID:

Insurance: ID:

Assignment Of Benefits/Financial Responsibility

I request that payment of authorized medicare and other benefits be made on my behalf to Soundview Medical Supply, LLC for products and services that they have provided for me. I further authorize a copy of this agreement to be used in place of the original and authorize any holder of medical information about me to release to the centers for medicare and medicaid services and its agents or others, any information needed to determine these benefits or compliance with current healthcare standards. I acknowledge financial responsibility for all charges if inaccurate insurance information is given at time of service and the information is not corrected prior to my insurance company's timely filing limit.

Customer Signature: Date:

Relationship If Not Signed By Patient (Parent, Guardian or DPOA):

Patient Acknowledgement Of Receipt Of Notice Of Privacy Practices & Other Important Forms

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

I acknowledge that I have received a copy of the Soundview Medical Supply welcome packet that includes the following: current notice of privacy practices, medicare supplier standards, bill of rights, company mission statement, rights and responsibilities, information and/or instructions when applicable on company products and services, including warranty and return information.

Customer Signature: Date:

Relationship If Not Signed By Patient (Parent, Guardian or DPOA):

To report concerns about patient safety and quality of care, please contact Soundview at 800-845-4925 or Joint Commission at 800-994-6610