2 Pond Park Road-Suite 102
Hingham, MA 02043
Durable Medical Equipment Authorization

Receipt/Delivery/Fitting/Return Policy: I acknowledge instruction on use and receipt/delivery of the above mentioned device. I understand this device has been fitted especially for me and cannot be returned.

Personal Health Information: I understand that my personal information will only be released for the purposes of treatment, payment and health care operations.

Medicare Assignment for Covered Services: I certify the information given by me in applying for payment is correct. I request payment of authorized benefits be made on my behalf.

Payment Responsibility: I understand I am responsible for the cost of this device. I hereby authorize payment for medical services/devices directly to my provider. I represent that I have insurance coverage and do hereby authorized South Shore Orthopedics, LLC to release and obtain all information necessary to secure payment of said benefits. If my insurance fails to pay South Shore Orthopedics, LLC in full, I agree to pay all unpaid balances.

Off the Shelf Products/Return Policy: Off the shelf products have limited manufacturer warranty against defects in material and workmanship. Item(s) received are medical products that can't be re-dispensed. Replacements may be allowed for defective products only.

I acknowledge that I have reviewed and understand my Patient Rights and Responsibilities.

Proof of Delivery: I verify that I have received the item listed on the attached page and will be financially responsible for any portion not covered by insurance. I am satisfied that it is in good working condition. I have read and agree to the terms and conditions stated above.

Please contact PRL Billing Services at 866-831-1190 with any questions regarding your bill.

Signature (Patient, Guardian or Parent of Minor) This product is supplied by SSO, LLC	Date Patient is responsible for DME coverage