Finnegan HEALTH SERVICES

1501 N University Ave | Ste 400
Little Rock, AR 72207
Toll-Free: **1-888-789-6600**
Fax: **501-663-6668**

www.finneganhealth.com
wecare@finneganhealth.com

Patient ID #: _____

To avoid interruption of medical supply service — within 10 days of receiving — **sign, date, and return this form** using the provided envelope.

Patient Name: **Date of Birth:**

Address:

City/State/Zip:

Phone #: **Email:**

IMMEDIATE ACTION REQUIRED

To whom it may concern: Finnegan Health Services has been requested to provide one or more of the following products: bladder control, diabetic, urinary, ambulatory, ostomy, bath safety, or nutritional supplies. Thank you for choosing us to provide your medical supplies.

We are required by your insurance company to have a signed "CONSENT FORM" on file. This form gives us permission to bill your insurance for your supplies as you request them, and it provides proof that you received a copy of our current client bill of rights and privacy policy. If you have any questions please call our toll-free number: 1-888-789-6600. Thank you for your prompt attention.

Sincerely,
Finnegan Health Services

Consent to Provide Services

I request that payment of authorized Medicare, Medicaid, and/or private insurance benefits be made either to me or on my behalf to Finnegan's Inc. dba Finnegan Health Services for any services furnished to me by Finnegan Health Services. I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services and/or my private insurance, and its agents, any information needed to determine these benefits for related services.

I understand that Finnegan Health Services reserves the right to review all agreements on an individual basis to determine the continued acceptance of assignment for Medicare, Medicaid, and/or any other medical insurance companies. In the event medical necessity no longer exists or my payer no longer deems my supplies to be covered, I understand I must return the unopened, reusable supplies to Finnegan Health Services so they may refund my insurance. I understand I must notify Finnegan Health Services immediately if any information changes such as my address, physician, or insurance eligibility. I may be held responsible for payment if services are denied because I did not report these changes.

I have received and understand my Patient/Client Bill of Rights, Medicare DMEPOS Supplier Standards, Notice of Privacy Practices, complaint procedures, and a listing of services provided by Finnegan Health Services. I understand I may have to meet certain requirements for coverage and I may have a deductible and/or co-pay according to my insurance plan. These estimated amounts will be provided before services are rendered. In addition, I agree that Finnegan Health Services may contact me in the future via telephone or other means of communication regarding ordering medical supplies. Medical supplies will be delivered within 3-4 business days after we have received the requested information and the physician's orders. I have received instruction and understand how to use my equipment and I understand that some equipment may have a limited warranty. I understand that I can call Finnegan Health Services at any time to receive additional instruction and warranty information on equipment.

SIGN HERE _____ **DATE HERE** _____

If the patient is unable to sign, a representative may sign **above on their behalf.*

Representative's Name (print) _____ **Reason Patient Cannot Sign** _____