MAXMED | MAXIMILIAN MEDICAL, LLC.
100 Commerce Way, #5, Hackensack, NJ 07601 | Phone: 201-880-7802 | Fax: 201-880-7804

Patient Disclosure Form

PRINT CLEAR FORM

Patient Name: Date of Delivery: / /

DME Item:

The forms listed below have been given and disclosed to me:
(Office Personnel Check all that apply. Patient initial acknowledging receipt of form)

- ☐ 1. Medicare Supplier Standards Int: _____
- ☐ 2. Patient Rights & Responsibilities Int: _____
- ☐ 3. Proof of Delivery Int: _____
- ☐ 4. Plan of Care (See Below) Int: _____
- ☐ 5. Complaint Process Int: _____
- ☐ 6. Advanced Beneficiary Notice Int: _____
- ☐ 7. Signature Agreement Form: Consent to Release, Assignment of Benefits, Same or Similar & Non-Coverage Int: _____
- ☐ 8. Warranty Letter (Found in User Manual) Int: _____
- ☐ 9. Product Instruction/Return Demonstration Int: _____
- ☐ 10. Service Availability (Hrs of Operation & Contact Info) Int: _____
- ☐ 11. Privacy Standards (HIPPA) Int: _____

I have read and received the above forms that are checked.

Patient Signature | Date / / | Signature of Office Personnel

PLAN OF CARE

To facilitate healing of the spine and soft tissue, and/or to reduce pain by restricting mobility of the trunk, and/or to facilitate healing following injury to spine/related soft tissue, and/or to otherwise support weak spinal muscles and/or a deformed spine. Follow up will be made to evaluate your response to your durable medical equipment.

1. The equipment has been properly fitted to me and is suitable for my needs.
2. I have received instructions on the proper care and safe usage of the equipment received. I have returned demonstration.
3. I understand that returns are only accepted on substandard items or unsuitable items.
4. I understand the same or similar guideline.

Beneficiary/Guardian Signature | Date of Delivery / / | Relationship to Patient (If Guardian Signed)

Reason Patient Cannot Sign

Signature of Office Personnel who Assisted Patient