SEE THE TRAINER, INC.

PATIENT PRODUCT AGREEMENT & Rx

PRESCRIPTION

Item # _____
Product Description_____
_____

Product Description _____

Ht_____ Wt_____ Activities_____

Physician's Name _____
Physician's NPI # _____
Physician's Phone (____) _____-_____ Date of Injury ___/___/_____

Patient Diagnosis: _____

Limb: ☐ Left ☐ Right ☐Bi ☐N/A (REQUIRED, Check one)

PATIENT INFORMATION

Marital Status: ☐Single ☐Married ☐Other

Name _____ Sex: ☐M ☐F Birth date: _____/_____/_____

SSN__ ____-_____-_____ Phone #s H/C: (____) _____-_____ W: (____) _____-_____

Billing Address _____ City _____ _____ State _____ Zip _____

Relationship to Insured ☐ Self ☐ Spouse ☐ Child Name of Insured _____

INSURANCE INFORMATION

Insurance Co. Name _____
Insurance Co. Address _____
City _____ State ___ ZIP _____ DOB_____
Phone (___) _____-_____
Adjuster _____
Group # _____
Claim # _____
Insured's Employer_____ Phone (___) _____-_____
☐ Private Insurance ☐ Medicare ☐ Workers Comp

SECONDARY INSURANCE INFORMATION

Insurance Co. Name _____
Insurance Co. Address _____
City _____ State _____ ZIP _____
Phone (___) _____-_____
Insured's Name _____
Policy # _____
Group # _____
☐ Private Insurance ☐ Medicare ☐ Workers Comp

LETTER OF MEDICAL NECESSITY:

This patient has an absolute medical necessity for the item listed. The patient's specific problem involves (include diagnosis codes):

_____

I certify the above prescribed item is medically indicated and, in my opinion, is a reasonable and necessary with reference to the standards of medical practice and treatment of this patient's condition. The patient will be wearing this brace for everyday use.

Physician's Signature _____ Date _____/_____/_____

I permit a copy of this authorization to be as valid as the original. I agree to use all products only in the manner for which they intended and not to attempt to make any modifications or changes of any kind or description in the product. These products are prescription only. These products are to be utilized only by my Health Care Provider. I agree that See The Trainer is not responsible for defects in, or damages caused by, non See The Trainer products.

CONSENT FOR TREATMENT, PROOF OF DELIVERY, AUTHORIZATION TO RELEASE INFORMATION AND PERMIT PAYMENT OF INSURANCE BENEFITS TO HEALTH CARE PROVIDER, SEE THE TRAINER, OR ITS BUSINESS PARTNERS

I acknowledge and I authorize See The Trainer to deliver, teach, administer, or perform, as necessary, the product and treatment prescribed by my Health Care Provider, and that I have received the product and such services. I authorize See The Trainer to submit a claim for such product to my insurer on my behalf, and I assign the benefits payable by my insurer for such product to See The Trainer. I authorize my Health Care Provider and See The Trainer to release any of my medical information required for my insurer to process the claim. I understand that I am responsible for, and I agree to pay, any portion of the amount due for such product not paid by my insurance, whether resulting from deductible, co-pays, or otherwise. I acknowledge that I have received and understand my Patient Rights and Responsibilities and the CMS supplier standards on the reverse side of this form. I also acknowledge that I have received and understand the information included on the tear-off form entitled "Important Information about the Medical Product You Are about to Receive".

Signature of Patient (*or responsible party*) _____ Date _____/_____/_____

Relationship to Patient: ☐ Self ☐ Parent ☐ Spouse

(facility fax #'s and e-mail addresses are located on the Locations tab of this web site)