

Patient Service Agreement

I, _____, authorize the release of any medical or other
(Patient First and Last Name)
information necessary, for Carolina Diabetic Supply Group, Inc. to process my request for diabetic supplies and submit claims to my insurer.

I also authorize payments of medical benefits to Carolina Diabetic Supply Group, Inc. for services and supplies I have received from Carolina Diabetic Supply Group, Inc.

If my insurance company sends the payments directly to me for any supplies furnished by Carolina Diabetic Supply Group, Inc. I will either forward all checks from my insurance company, or write a personal check to Carolina Diabetic Supply Group, Inc.

I will notify Carolina Diabetic Supply Group, Inc. immediately of any change in my insurance coverage.

I have received and understand the Patient Bill of Rights, Home Safety Information and The Privacy Notice and Medicare DMEPOS Supplier Standards.

I have been instructed and understand the warranty coverage on the product I have received.

I confirm that I have successfully completed training or am scheduled to begin training in the use of my glucose monitor and supplies. In addition, I am capable of using the test results to assure appropriate glycemic control.

By signing this form I authorize the staff of Carolina Diabetic Supply Group to contact me by phone, fax, mail, or e-mail concerning my account.

Patient Signature

Date Signed