Hawley Lane
SHOES
We fit your feet © We change your life.

PATIENT AGREEMENT

I authorize the release of any medical information necessary to process this claim. I understand that Hawley Lane Shoes will only use my protected health information (PHI) in accordance with the Health Information Portability and Accountability Act (HIPPA). I am allowed to request a copy of my HIPPA rights as a Center for Medicare and Medicaid Services (CMS) durable medical equipment supplier upon request. I understand that I am responsible for any unmet portion of my Medicare deductible not paid by a supplemental insurance company. I further understand that Medicare pays 80% of covered charges and I am responsible for the remaining 20% in the event of a refusal of payment by a supplemental insurer or in the absence of a supplemental insurance plan. I also understand that in the event of a denial of payment by Medicare, I am responsible for the cost of any merchandise dispensed by Hawley Lane Shoes.

I acknowledge that I have received instructions on how to properly break-in and wear my new orthopedic shoes and/or inserts and that I will contact Hawley Lane Shoes or my physician if any problem or concern arises.

I have the right to refuse any services provided by Hawley Lane Shoes. I also have the right to request a price quote on any merchandise dispensed by Hawley Lane Shoes. I request the payment of benefits provided by Hawley Lane Shoes to myself or the party who accepts the Medicare assignment. I authorize the payment of medical benefits for the supplies and services described in this claim. I also certify that I have received all merchandise in accordance with my doctor's prescription and that I am satisfied with the items prescribed. I also certify that I have not received any other diabetic shoes or inserts as a covered benefit by Medicare Part B in this calendar year.

Delivered at: ☐ **Shelton** ☐ **Norwalk** ☐ **Stamford**

I have received:

Quantity: # of Pairs _____ Prefabricated Make/Model: # _____

Quantity: # of Pairs _____ Inserts

☐ **Items delivered were assessed for structural safety**

Patient Name: _____ Date: _____
(Please Print)

Patient Signature: _____

Clinician/Fitter Signature: _____