Tactile MEDICAL®

PATIENT CONSENT

PATIENT CONTACT INFORMATION

NAME | DATE OF BIRTH

My address is a: ☐ Private home/apartment ☐ Facility*
**Assisted Living, Skilled Nursing, Group Home, etc.*

Preferred language (if other than English):

Phone numbers:
(_____) _____ ☐ HOME ☐ CELL ☐ WORK
(_____) _____ ☐ HOME ☐ CELL ☐ WORK

Phone numbers:
(_____) _____ ☐ HOME ☐ CELL ☐ WORK

Email address: _____

By providing my contact information, I authorize Tactile to contact me regarding my order, account or other services or products provided by Tactile. A detailed description of my rights was provided to me in the Notice of Privacy Practices. Tactile will never disclose your personal information to any unrelated third-parties. You may view our full privacy statement on our website.

FAMILY/LEGAL GUARDIAN/EMERGENCY CONTACT(S)

_____ ☐ Authorized to accept shipment, set up payment plans, and schedule training on my behalf ☐ Authorized to discuss PHI/emergency contact
NAME | RELATIONSHIP | PHONE

_____ ☐ Authorized to accept shipment, set up payment plans, and schedule training on my behalf ☐ Authorized to discuss PHI/emergency contact
NAME | RELATIONSHIP | PHONE

☐ Patient does not wish to share Family/Legal Guardian/Emergency Contact information with Tactile Medical.

CONSENT FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

– I understand that Tactile Medical (Tactile) originates, collects and maintains paper and/or electronic records describing my Protected Health Information (PHI) such as health history, diagnosis, symptoms, test results, etc. I consent to the use and disclosure of my PHI by Tactile, its staff, and its business associates for treatment, payment and healthcare operations.

– I understand I have a right to request restrictions or revoke any use and/or disclosure of my PHI by Tactile. I understand that the Tactile Medical Notice of Privacy Practices is included in the device package and that I can contact customer service at 1.833.3TACTILE (1.833.382.2845) if I have questions. This authorization is effective for five years unless otherwise provided by law.

– I authorize and consent to the release by my healthcare providers to Tactile and any insurance company(ies), all PHI necessary to complete my equipment order.

ASSIGNMENT OF BENEFITS & FINANCIAL RESPONSIBILITY

I assign payment of medical benefits to Tactile and direct any insurance (payer) to make payment on my behalf directly to Tactile for medical equipment provided. Any costs not covered by my insurance are my responsibility. If for any reason insurance will not complete the purchase of the device (including change of insurance), I must 1) pay the remaining cost out of pocket or 2) return the device and pay my assigned balance. In the event my insurance makes payment directly to me for the medical equipment, I am responsible for ensuring payment in full is made promptly to Tactile.

RETURN POLICY

Tactile Medical does not accept returns or provide refunds for products once the original packaging has been opened. Unopened products may be returned within sixty (60) days of the date of shipment. If you receive a product(s) that is incorrect due to a Tactile error, Tactile will exchange the product(s) if the Company is notified within sixty (60) days of the date of shipment. For equipment rented through insurance, the patient is responsible for outstanding financial obligations for the period in which they had the product.

PATIENT SIGNATURE

I agree to all the terms and conditions listed above.

PATIENT OR AUTHORIZED SIGNER NAME* (PLEASE PRINT) | SIGNATURE | DATE

*Authorized Signer can be Legal Guardian, Power of Attorney, or Family member.

Tactile Medical
3701 Wayzata Blvd, Suite 300
Minneapolis, MN 55416 USA

Customer Service
Toll Free Tel: 833.382.2845 (833.3TACTILE)
Toll Free Fax: 866.435.3949

Hours: 7 a.m. to 7 p.m. CT, Monday–Friday
tactilemedical.com

Tactile MEDICAL®