Active Healthcare, Inc.™
helping you breathe easy™

9104 Falls of Neuse, Suite 100
Raleigh, NC 27615
P: 919.870.8600 ● F: 919.844.2802
www.activehealthcare.com

ACHC ACCREDITED

ASSIGNMENT OF BENEFITS, RIGHTS AND RESPONSIBILITIES

I HEREBY AUTHORIZE the release of any medical or other information necessary to process this claim, and authorize payment of medical benefits to Active Healthcare, Inc. for services rendered.

I UNDERSTAND that upon receipt of products provided by Active Healthcare, Inc., I assume responsibility for any deductible, co-pay, or other balance not covered by my insurance carrier.

I AGREE to be personally and fully responsible for any amounts not paid by my insurer, I have read, understand and agree to all the terms of Active Healthcare's "Standard Business Practices," and agree to pay all legal, finance charge, and collection fees.

I WILL NOTIFY Active Healthcare in the event my insurance, address or other contact information changes.

I AGREE to be responsible for the cost of replacement shipments if I have failed to notify Active Healthcare of shipping address changes.

I AGREE that Active Healthcare is not liable for any incidental or consequential damages resulting from defective equipment, and that Active Healthcare's liability is limited to the repair or replacement of the equipment. I agree that I have received a copy of the Medicare Supplier Standards.

I AGREE and consent to all the terms and practices as described in Active Healthcare's HIPAA Privacy Notice. All notices available online in the Forms Library on ActiveHealthcare.com.

I AGREE that should any insurance payment be made directly to the insured for monies due on this account, I agree to immediately pay over these funds to Active Healthcare, Inc.

_________________________________ _________________

Patient Name DOB

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Address

_________________________________ _________________________________

Phone Email

_________________________________ _________________________ _________

Parent/ Guardian Signature Relationship to Patient Date

Please fax completed forms to 919-844-2802 or
Email to: supply@activehealthcare.com