Tactile MEDICAL™

PATIENT CONSENT

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. A detailed description of my rights was provided to me in the Notice of Privacy Practices. This authorization is effective for 5 years unless otherwise provided by law.
– I consent to the release of PHI by Tactile to my healthcare providers and insurance company(ies). I authorize and consent to the release by my healthcare providers to Tactile and any insurance company(ies), all PHI necessary to secure payment.
– I understand Tactile may desire to review de-identified health information for the purposes of clinical research, evaluation of patient outcomes, or clinical protocol development. I consent to the release and use of my de-identified information so long as Tactile ensures that I cannot be identified through release and use of that information.

ASSIGNMENT OF BENEFITS

I assign payment of medical benefits to Tactile and direct any payer to make payment on my behalf directly to Tactile. I understand that all costs not covered by my insurance are my responsibility. I understand that in the event my insurance company makes payment directly to me for the medical equipment provided by Tactile, I am responsible for ensuring payment in full is made promptly to Tactile.

CONTACT INFORMATION

Preferred language (if other than English): ________________________

Best number(s) to contact during daytime hours:

Home (______)____________________ Cell (______)____________________ Work (______)____________________

☐ I do **NOT** authorize Tactile to leave messages for me.

Email address: ____

By providing my email above, I authorize Tactile to email me regarding my order or other services or products provided by Tactile. I understand that emails containing PHI will be encrypted. Encrypted email will require that I click on a provided link and create a password in order to review the secure email.

ALTERNATE CONTACT(S)

I authorize Tactile to contact or respond to inquiries from the following individual(s):

NAME	RELATIONSHIP	PHONE
NAME	RELATIONSHIP	PHONE

MEDICARE BENEFITS

Do you have Medicare?

☐ Yes ☐ No

PRIMARY ADDRESS

My address is a:

☐ Private home/apartment ☐ Assisted Living ☐ Skilled Nursing ☐ Group Home

PATIENT SIGNATURE

By signing this, I agree to all the terms and conditions listed above.

SIGNATURE OF PATIENT OR AUTHORIZED PERSON	IF AUTHORIZED PERSON, PRINT NAME AND DESCRIPTION OF AUTHORITY TO SIGN (I.E. POWER OF ATTORNEY, LEGAL GUARDIAN, ETC.)	DATE

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