ELECTRICAL WAIVER

Dear Valued Patient,

In order for your medical equipment to function properly, your electrical outlet must be properly grounded.

By properly grounding your outlets, you are ensuring the safe use of the equipment and you are protecting your home from electrical hazard. We feel that this is very important.

If during delivery of your medical equipment today, our representative determines that your outlet is not grounded, and you continue to use your equipment, you are releasing us of all liabilities associated with the use of the equipment.

We recommend that you arrange with a qualified electrician to have your outlets properly grounded if applicable.

Yours truly,

Center Manager

Understood and agreed to by: _____

Patient and/or Guardian Signature

_____

Date

*

Metolina Medical Associates

DME supplies Policy Update

Effective 12/2/2016

At Metrolina Medical we strive to provide our patients with the best possible care in a timely, efficient, caring and supportive environment. We continuously evaluate process and procedures to improve efficiency, quality of care, outcomes and patient satisfaction.

In an effort to continue providing you with the best possible care the following policy changes have been made.

Processes: Ordering, dispensing and billing durable medical equipment for sleep.

- All supply requests must now be made through our CPAP supply line at 888 -239-0616
- A credit card must be on file before an order will be placed.
- We will continue to bill your insurance as a courtesy to you. If your insurance does not cover the supplies ordered, the credit card on file will be charged.
- You will be notified only once your supplies are ready for pickup.
- If you paid by credit card a receipt will be provided for you to submit to your Insurance Company for reimbursement.
- You will have thirty days to pick-up supplies before they are restocked.
- Once restocked there will be a $ 15.00 charge for re-pulling them.

These changes will provide you with a more efficient way of ordering and receiving your Sleep DME supplies. As always we thank you for allowing us to serve you and care for all your healthcare needs.

Print Name_____

Signature _____

Date _____ Time _____

CARE OF EQUIPMENT

MASK

DAILY: Using a cloth and mild soap, wipe the mask both inside and out. Rinse well, allow to air dry. Blue dawn dish soap is recommended.

NASAL PILLOWS/CUSHION

DAILY: Wash thoroughly with mild soap. Rinse well and air dry. DO NOT USE RUBBING ALCOHOL.

MASK FRAME

WEEKLY: wash with warm soapy water and let air dry. Be sure all parts of mask are dry before use.

HEADGEAR

Wash headgear with mild soap, rinse well and air dry.

HUMIDIFIER CHAMBER

Each morning, check the level of remaining water. Every other day empty water, wash with soap and water and let air dry. Each evening, fill with distilled water.

TO DISINFECT: Place one part white vinegar to three parts water into the water chamber. Soak for thirty minutes. Rinse well and air dry.

FILTER

MONTHLY: White Filter-These are disposable and are NOT washable.

Insurance coverage for supplies will vary depending on specific coverage guidelines. Some insurance companies will NOT cover replacement supplies if any equipment is still under rental. You are responsible for any balance that is not covered by your insurance plan.

Recommended replacement:
1 per month: cushion and filter
1 per 3 month: mask frame and tubing
1 per 6 month: water chamber and whole mask

Please call the sleep lab directly to order new supplies.
1-888-239-0616 – SLEEP LAB

Metrolina Medical Associates

Payment Authorization Form

Patient Information:

Name: _____ DOB: _____

At Metrolina Medical Associates we require keeping your credit or debit card on file as a method of payment for the Durable Medical Equipment provided through our Sleep Study Clinic before supplies are given. A receipt will be given upon pickup of supplies to submit to your Insurance Company for reimbursement.

Credit Card Information:

Card Type: ☐ Mastercard ☐ Visa ☐ Discover

Cardholder Name: _____ Billing Zip Code: _____

Card Number: _____ Expires: _____/_____ CVV2: _____

Statement Date	Statement Amt	Date Card Drafted	Notes	Initials

I (we), the undersigned, authorize and request Metrolina Medical Associates to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility. This authorization relates to all payments for supplies given through our sleep lab. This authorization will remain in effect for all DME given.

Patient Name (Print): _____

Patient Signature: _____ Date: _____ / _____ / _____