Adaptive Prosthetics: Delivery Receipt

52 National Dr, Glastonbury, CT / 567 Vauxhall St Ext, Waterford, CT / 113 Salem Tpke, Norwich, CT / 35 Wells St, Westerly, RI

PATIENT INFORMATION	PATIENT NAME: ______________________________DATE: ____________________ DELIVERY ADDRESS:____
PROVISION OF SERVICES	● I have received the following orthosis/prosthesis/ DME from Adaptive Prosthetics. ● The items noted below have been: a) fabricated according to the manufacturer's guidelines b) assessed for structural safety prior to patient delivery c) verified, authenticated, and unadulterated.

Quantity	L-Code Descriptor	Detailed Description (brand name, model number, serial number, narrative description)	Amt Billed

PATIENT SATISFACTION	• I am satisfied with the fit and clinical function of my orthosis/prosthesis.
WARRANTY INFORMATION	• I understand that the components of my orthosis/prosthesis are warranted for 90 days, after which a service charge, based on hourly rate and materials will be applied. Prosthetics components and prefabricated orthoses carry individual manufacturer's warranty. These warranties vary. Our warranty does not apply to anatomical changes, misuse of the device or alterations made by anyone other than Adaptive Prosthetics. Adaptive Prosthetics will: • Notify all Medicare beneficiaries of the warranty coverage, and will honor warranties under applicable law. • Repair or replace, free of charge, Medicare-covered equipment that is under warranty. • Provide owner's manual with warranty information to beneficiaries for all durable medical equipment where this manual is available.
PATIENT EDUCATION	• I have been advised on the fit and function, care and use, maintenance, and precautions (i.e. skin issues and infection control) of my device. • I have been informed on how to report any failures or malfunctions, and when and to whom to report changes in my physical condition. • I have received written instructions specific to my device if available. • If I am a Medicare beneficiary, I understand the Medicare DMEPOS Supplier Standards and understand my Patient Bill of Rights.
PAYMENT INFORMATION	• I agree to release any necessary information to process this claim through my insurance(s), and assign payment to Adaptive Prosthetics. • I understand should for any reason that my insurance does not disburse payment, I will owe what the insurance claim says I owe.
SIGNATURE	**I HAVE READ, UNDERSTOOD, AND HEREBY AGREE TO ALL OF THE STATEMENTS NOTED ABOVE.** ____ ______________ PATIENT OR AUTHORIZED REPRESENTATIVE SIGNATURE DATE If Representative Print Name Relationship