

Patient Name: _____ DOB: _____ Patient ID#: _____

PATIENT AUTHORIZATION, ACKNOWLEDGEMENT & CONSENT

For Services Indicated on the Corresponding Delivery Ticket or Listed Here:

- 1. Provision of Prescribed Medical Equipment & Supplies Acknowledgement.** The undersigned, as the above-named patient ("Patient"), or the Patient's guardian or authorized representative ("Representative"), acknowledges that by signing this Patient Authorization, Acknowledgement & Consent ("Acknowledgement"), the Patient agrees to rent or purchase from Synapse Health, Inc. ("Synapse") the equipment, supplies and services (collectively, "Services") identified above or on the corresponding delivery ticket. The Patient or Representative understand that Synapse is providing the Services in accordance with the order provided by the Patient's treating physician or other health care provider ("Provider"). The Patient or Representative acknowledge and agree that Synapse and its affiliates and agents are not liable for any acts or omissions of the Provider related to the diagnostic, prescriptive, or other functions performed by the Provider in determining that the Services are medically necessary.
- 2. Patient Authorization & Assignment of Benefits.** The undersigned requests that payment of the authorized benefits to which the Patient is entitled under Medicare, Medicaid and/or other health plans (collectively, "Insurance") be made to Synapse for any Services furnished to the Patient by Synapse. The Patient or Representative authorize any holder of the Patient's medical information to release to the Patient's Insurance and its agents any information needed to determine benefits for the Services or benefits for related services. If Insurance payment(s) are made directly to the Patient or Representative on an assigned claim, the Patient or Representative will endorse all checks for the Insurance payment(s) to Synapse or otherwise reimburse Synapse for the amount due for the Services. The Patient or Representative authorizes Synapse to act as the Patient's representative in any appeal(s) process regarding claims for the Services, including any and all denials of claims for Services on the behalf of the Patient. On assigned Medicare claims, Synapse agrees to accept the applicable Medicare allowable amount (including deductibles and co-payments) as payment in full for the Services.
- 3. Financial Responsibilities Acknowledgement.** The Patient or Representative agree to provide complete and accurate Insurance information to Synapse, that it is their responsibility to notify Synapse of any changes to the Patient's Insurance, and that delays in providing this information could result in the Patient receiving a bill for Services. If the Services are not covered by the Patient's Insurance, or if the Patient loses Insurance coverage at the time Services are provided to the Patient, the Patient or Representative agree to reimburse Synapse for the Services in accordance with Synapse's applicable self-pay rate(s) for the Services.

Synapse will verify the Patient's Insurance coverage, including obtaining prior authorization from the Patient's Insurance, where applicable; however, this is not a guarantee that the Services will be covered by Insurance. The Patient or Representative authorize Synapse to contact the Patient's Insurance to discuss any questions regarding network participation, benefit eligibility, and/or benefit coverage.

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The Patient or Representative acknowledges that the Patient may be required to pay a copayment, deductible, or coinsurance (collectively, "Cost-Share") for the Services. The undersigned acknowledges that Synapse will submit claims for the Services to Insurance on the Patient's behalf and agrees that he or she will be financially responsible for any account balance owed as a result of the Patient's Insurance benefits, including any Cost-Share amounts or amounts for non-covered services.

4. **Return Policy Acknowledgement.** The Patient or Representative understand and acknowledge that returns for certain purchased Services may only be accepted within 14 calendar days of purchase. If Services may be returned, the Services must be in the original, unopened and undamaged packaging. Used Services, custom-made Services, Services worn against the body, and/or Services that were modified in any way are not eligible for return.
5. **Warranty Policy Acknowledgement.** Synapse honors all manufacturers' warranties for new Services. Unless otherwise required by applicable law, Services without a specific warranty will be under warranty for damage or manufacturer's defect for up to 30 calendar days from the date of purchase, as long as damage was not due to Patient's negligence or misuse.
6. **Rental Agreement.** The Patient or Representative acknowledge and understand that certain Services may be classified as capped rental items by Insurance. This classification means that Insurance may cover rental payments for a defined "Rental Period" (e.g., 10 months), as determined by the Patient's Insurance policy. After this Rental Period, and in accordance with Insurance's guidelines, ownership of the equipment will transfer to the Patient. Transfer of ownership will only be completed once payment in full is received for all Rental Periods from the Patient and the Patient's Insurance, including any Cost-Share amounts. During the Rental Period, and until ownership is officially transferred, the equipment will remain the property of Synapse. Once ownership has been transferred, the Patient or Representative accepts full responsibility for arranging any necessary servicing or repairs. This capped rental provision does not apply to equipment classified as "rental-only" (e.g., ventilators) or items not considered capped rental equipment, such as oxygen equipment. Furthermore, the Patient or Representative understand and acknowledge that it is the Patient's or Representative's responsibility to notify Synapse immediately if the Patient stops using the rental equipment for any reason. This includes, but is not limited to, changes in the Patient's condition (e.g., hospital or nursing home admission) or if the Patient's Provider determines the equipment is no longer medically necessary.
7. **Receipt of Patient Services Guide.** Patient or Representative certify that the Patient or Representative has received and understands the information outlined in the **Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Supplier Standards** and **Synapse Health Patient Services Guide** that includes, but is not limited to, the following information:
 - Billing & Payment Information
 - Capped Rental & Routinely Purchased Items
 - Complaint & Grievance Policy
 - Emergency Preparedness & Safety
 - Infection Control
 - Notice of Non-Discrimination (On Synapse's Website)
 - Notice of Privacy Practices
 - Patient Rights & Responsibilities

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8. **Release of Information Authorization.** The Patient or Representative understand that in the course of providing medically necessary Services Synapse will receive and share information and knowledge about the Patient's health, physical condition, and treatment, (collectively, "Protected Health Information" or "PHI"). The Patient or Representative further understand that Synapse may, in certain circumstances, and authorize Synapse to, use or disclose the Patient's PHI for the purposes of the Patient's treatment, to seek payment for the Services, and/or perform other health care operations without additional consent as outlined in the Synapse Notice of Privacy Practices ("NPP"). The Patient or Representative understand that he or she may request certain restrictions on Synapse's use and disclosure of the Patient's PHI or seek more information on how the Patient's PHI is used or disclosed by following the directions listed in Synapse's NPP.
9. **Consent to Contact Authorization.** The Patient or Representative understand that Synapse offers several options to receive important information regarding the Services provided by Synapse. Through the selection on the next page, the Patient or Representative authorize Synapse and its agents to contact the Patient or Representative through these methods and expressly consent to receive autodialed, pre-recorded calls, text messages, and electronic correspondence, as outlined in the preferences below.

The Patient or Representative acknowledge that communications by voicemail, text messaging, and email (if unencrypted) are not secure and may be at risk of being intercepted by parties other than the intended recipient. The Patient or Representative understand that consent is optional, and the Patient or Representative may opt-out at any time by following the directions included in the communication or by contacting Synapse at 1.888.33.MYDME (1.888.336.9363).

Preferred Phone Number: _____ ☐ Landline ☐ Cell Phone
Secondary Phone Number: _____ ☐ Landline ☐ Cell Phone
Email Address: _____

- ☐ Yes ☐ No I authorize Synapse to leave detailed, health related voicemails at my preferred phone number.
- ☐ Yes ☐ No I authorize Synapse to contact me via email related to the Services Synapse is proving me (e.g., order status, reorder reminders, etc.).
- ☐ Yes ☐ No I authorize Synapse to contact me via standard text message, with messages that may contain protected health information (PHI), such as order number, type of Services received, etc.

10. **Designated Authorized Representative.** The undersigned authorizes Synapse to disclose information about the Services provided to the Patient by Synapse, including related PHI, to the following designated individual. If the Patient is unable to sign, the Patient's designated authorized representative must provide copies of court ordered documentation (e.g., Power of Attorney, Guardianship) to sign on the Patient's behalf.

Printed Name: _____
☐ Authorized Representative ☐ Power of Attorney ☐ Legal Guardian

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11. **Certification Statement & Signature.** By signing below, the undersigned hereby authorizes and consents to the provision of Services provided to the Patient by Synapse. Further, the undersigned certifies the undersigned's understanding and agreement with the information outlined in this **Acknowledgement** and the **Synapse Health Patient Services Guide**. The undersigned confirms that this information has been explained and that he or she has had the opportunity to ask questions. Should the undersigned have any questions or need support related to the Services provided by Synapse, the undersigned can contract Synapse directly by calling toll free at 888.33.MYDME (888.336.9363).

Print Name of Patient or Patient's Authorized Representative

Relationship to Patient

Signature of Patient or Patient's Authorized Representative

Date