PINNACLE
Medical Solutions

6856 Cobblestone Blvd // Southaven, MS, 38672 // 1-888-416-0008

ASSIGNMENT OF BENEFITS

This form is required to bill insurance (Private or Group Insurance and Medicare) on your behalf. Please complete and return today.

Name of insured (Please print):_____

I request that payment of authorized insurance benefits be made on my behalf to Pinnacle Medical Solutions, LLC ("Pinnacle") for any equipment or services provided to me by Pinnacle and remit payment to the following address:

Pinnacle Medical Solutions, LLC
6856 Cobblestone Blvd.Southaven, MS 38672

Hours of Operation:
8:00 am – 5:00 pm, Monday through Friday

For the benefits allowable and otherwise payable to me as payment towards the total charges for services rendered.

- **I agree to pay any co-payments and deductibles that may apply in a current manner**.
- I authorize the release of any information pertaining to my medical history and/or current diagnosis and treatment, and information pertaining to my insurance coverage and benefits to Pinnacle.
- I authorize Pinnacle to disclose medical information necessary for the purpose of obtaining reimbursement.
- I authorize Pinnacle, and/or any of their affiliates, to contact me via telephone, mail, or e-mail regarding any medical equipment they have provided or in regards to my account.
- I authorize the holder of medical or other information about me to be released to the Social Security Administration or its intermediaries or carrier any information needed for this or a related Medicare Insurance claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits be made to the party who accepts assignment on any bills for services furnished to me. **I understand that I will be responsible for my yearly Medicare/Insurance deductible and co-insurance.**
- I accept responsibility for any and all medical equipment/supplies while in my possession. I acknowledge that I have received the Medicare Provider's Standard of Care and Patient Rights from Pinnacle and that I have received training with my medical equipment.

By signing this document, I am giving authorization of the above mentioned and acknowledging that I have received a copy of Pinnacle's Notice of Privacy Practices. This acknowledgement is required by the HIPAA to ensure that I have been made aware of my privacy rights.

Name of signer (print): _____ Date: _____

Signature of insured/ Guardian: _____ If not the insured, relationship to Insured: _____

CUSTOMER ORIENTATION FORM

Please sign below to confirm that you have received, reviewed, and understand the following:

- (page 1) Customer Orientation Form
- (page 2) Patient Satisfactory Survey
- (page 3) My Release of Information/Assignment of Benefits
- (page 4) DMEPOS Medicare Supplier Standards
- (page 5) My rights and responsibilities as a customer
- My Shipping Ticket detonating equipment and/or products and new patient packet delivered.
- (page 6) The safe use and proper operation of equipment and/or supplies; cleaning procedures; and warranty information.
- (page 7) Pinnacle's contact information, after hour information, organization objectives, and how to report a problem
- (page 8) HIPAA Privacy Notice
- (page 9) Pinnacle's Policy for Returns/Exchanges
- (page 10) Client/Patient Complaint Instructions. **KEEP FOR FUTURE USE.**
- The patient/caregiver is capable of using the test result to assure the patient's appropriate glycemic control.

INITIAL IF YOU AGREE WITH THIS STATEMENT: The patient/caregiver has successfully completed training on the use of the glucose monitor, test strips, and lancing device or the use of the Insulin pump and pump supplies; OR you have been scheduled to attend training.
INITIALS: _____

My signature attests that I have received, read, and/or been instructed on the above information.

Customer/ Responsible Party: _____ Date: _____