Frontier Medical

P.O. Box 1027, Bountiful, UT, 84010
Office, 801-979-4638 Fax, 801-807-0144

PATIENT INTAKE AND CONSENT FORM

Patient Name: _____

Date of Birth: _____

Height: _____ Weight: _____

Address: _____

City: _____

State: _____

Zip: _____

Email: _____

Phone: _____

☐ Yes Text ☐ No Text

DOL Case ID: _____

DOL Doctor: _____

Last Visit: _____

Doctor Phone #: _____

Home Health Care Co: _____

HHC Phone #: _____

Primary HHC Contact Name: _____

Authorized Rep, if any: _____

Caregiver, if any: _____

Relationship to Caregiver: _____

I. Consent to Provide Durable Medical Equipment (DME)

I consent to receive Durable Medical Equipment (DME) provided by Frontier Medical as part of my approved plan of care under the U.S. Department of Labor (DOL) Office of Workers' Compensation Programs (OWCP). DME is medically necessary equipment and appliances, prescribed by a qualified physician, for a claimant's extended use in treating or mitigating the effect of an accepted medical condition. I confirm that any equipment I receive through Frontier Medical is for legitimate medical purposes, as determined by my healthcare provider, for my personal use and not for resale.

II. Billing and Financial Responsibility

I understand that Frontier Medical will bill the OWCP program directly for covered charges. Frontier Medical agrees to accept the charge determination of the OWCP on covered services as payment in full, and will not seek reimbursement from me for any amounts not paid by OWCP due to application of its fee schedule or related reasonableness tests. However, I acknowledge

that if the OWCP program denies coverage for any portion of the equipment or services provided, or if the equipment or services are categorically not covered or fall outside the scope of the OWCP program, I may be held financially responsible for those charges. I agree to pay for any such non-covered or non-authorized items or services.

III. Assignment of Benefits (AOB)

I authorize the U.S. Department of Labor to pay benefits directly to Frontier Medical for the equipment and services provided. I understand that this assignment of benefits will remain in effect unless revoked by me in writing.

IV. HIPAA Acknowledgment and Consent to Use or Disclose Health Information

I acknowledge that I have read and understand Frontier Medical's Notice of Privacy Practices, available for download at https://www.ftmed.net, which describes how my protected health information may be used and disclosed in accordance with federal law. I understand that Frontier Medical may disclose information for treatment, payment, and healthcare operations, as defined under HIPAA to the U.S. Department of Labor or its agents as required to process claims or support my approved plan of care under the OWCP program.

V. Warranty Disclaimer

I ACKNOWLEDGE AND AGREE THAT FRONTIER MEDICAL MAKES NO WARRANTIES REGARDING THE DME PROVIDED. ANY MANUFACTURER'S WARRANTY PROVIDED WITH THE EQUIPMENT REMAINS SOLELY THE RESPONSIBILITY OF THE MANUFACTURER. FRONTIER MEDICAL SHALL NOT BE LIABLE FOR ANY DIRECT OR INDIRECT DAMAGES RESULTING FROM THE USE, MISUSE OR INABILITY TO USE THE EQUIPMENT.

VI. Signature and Authorization

By signing below, I acknowledge and agree to the above terms and confirm that the information provided is accurate to the best of my knowledge.

Patient Signature:

_____

Date: _____

Authorized Representative/Caregiver Signature: (if applicable)

_____

Date: _____