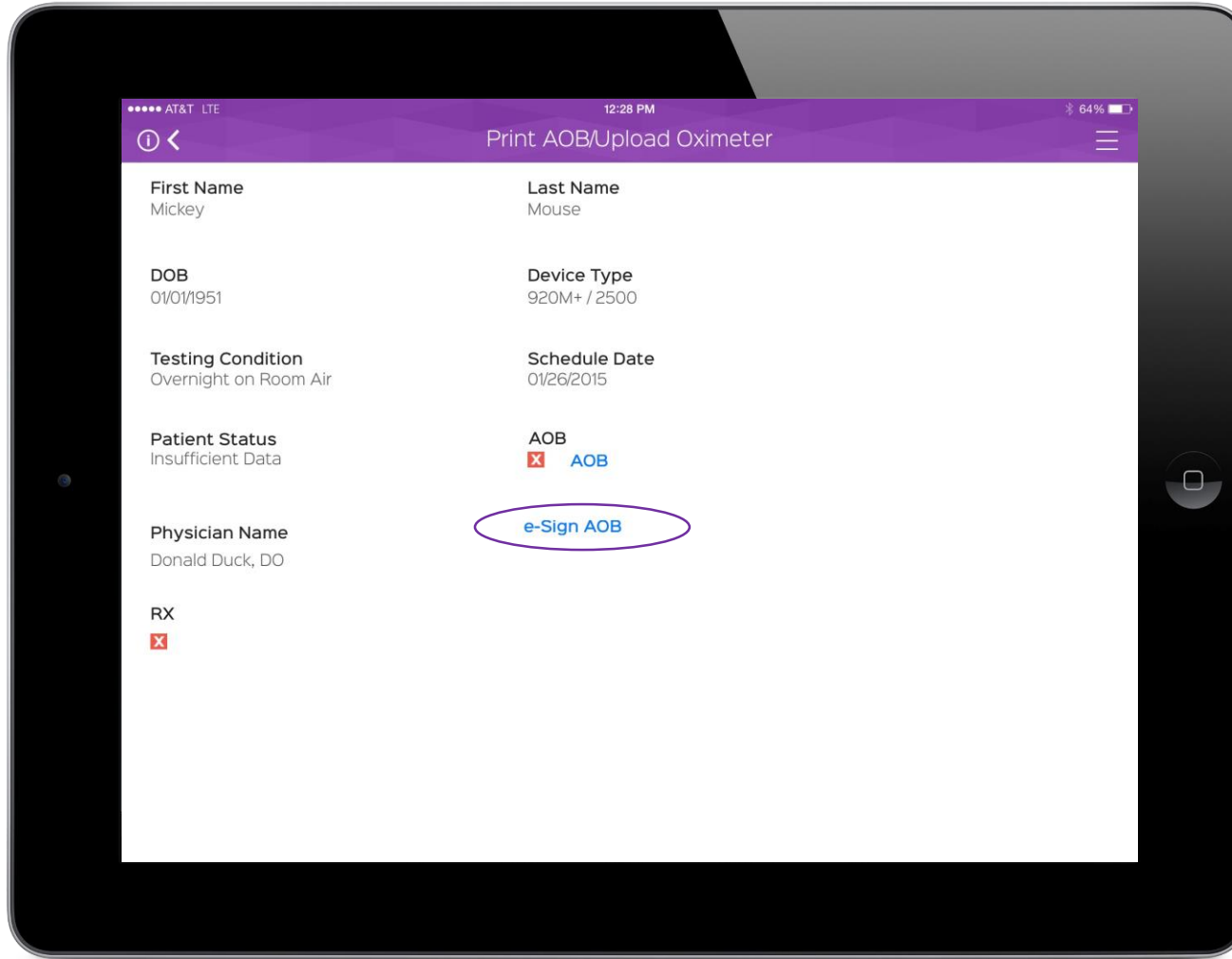
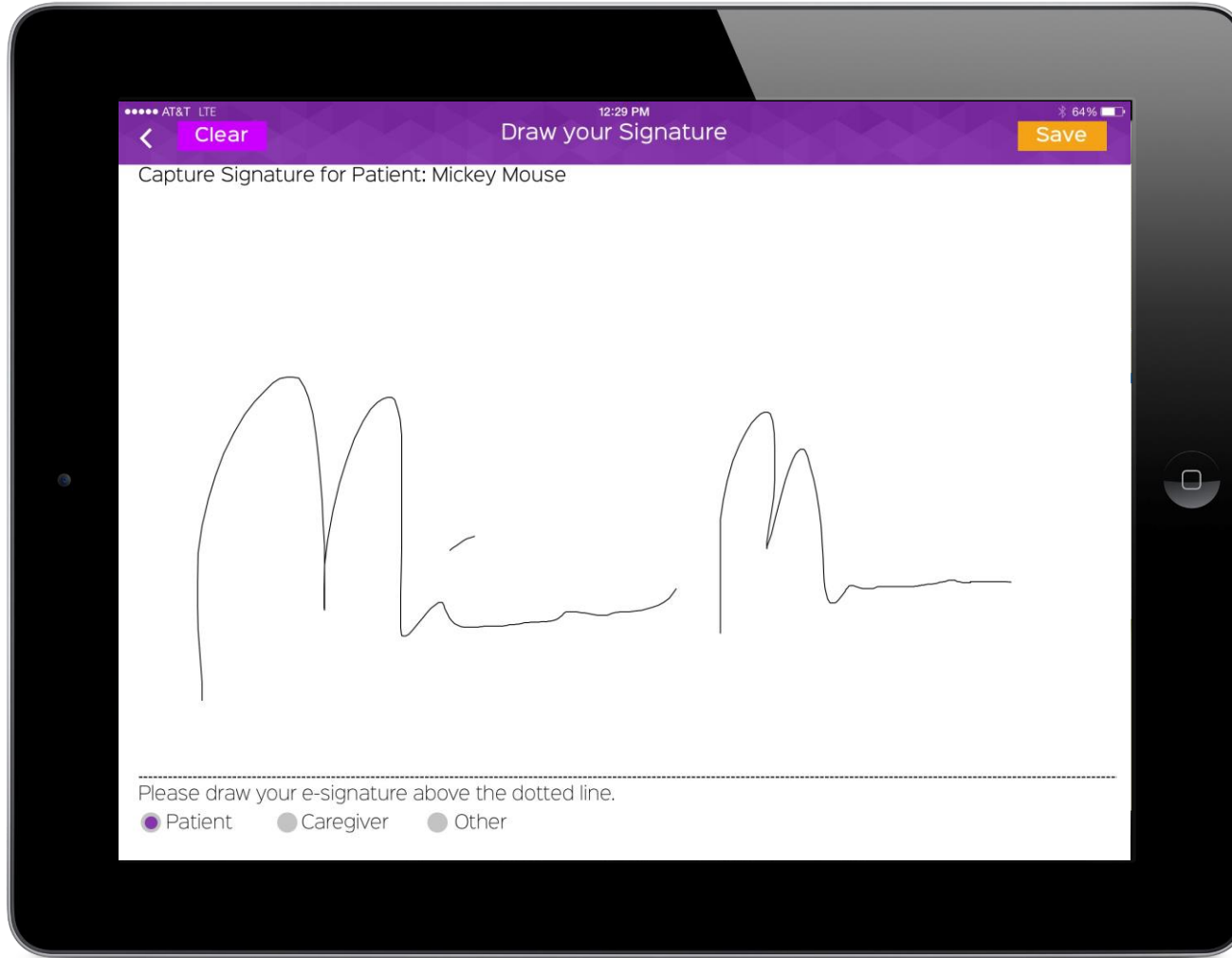


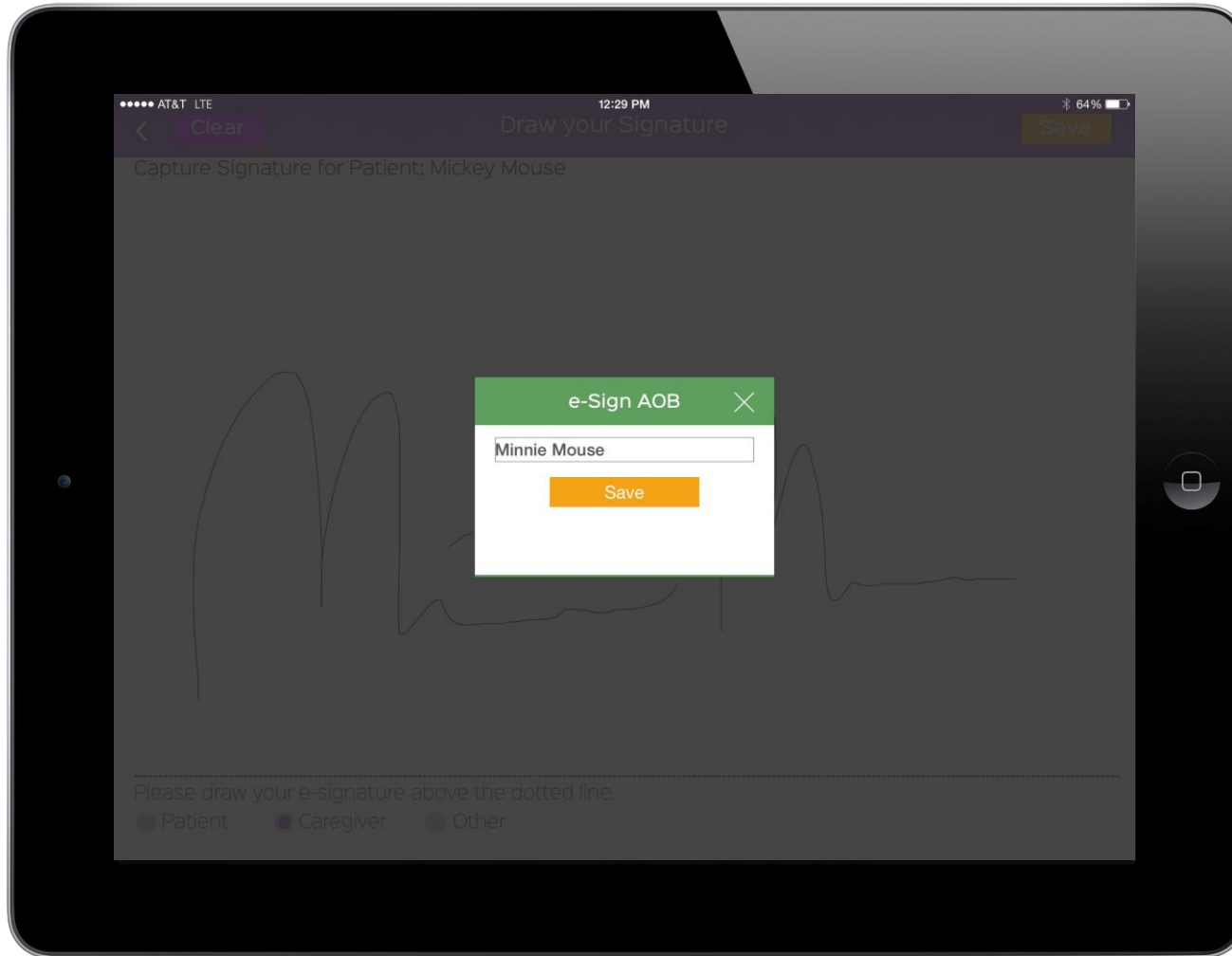
## Patient Selected: Click “e-Sign AOB”



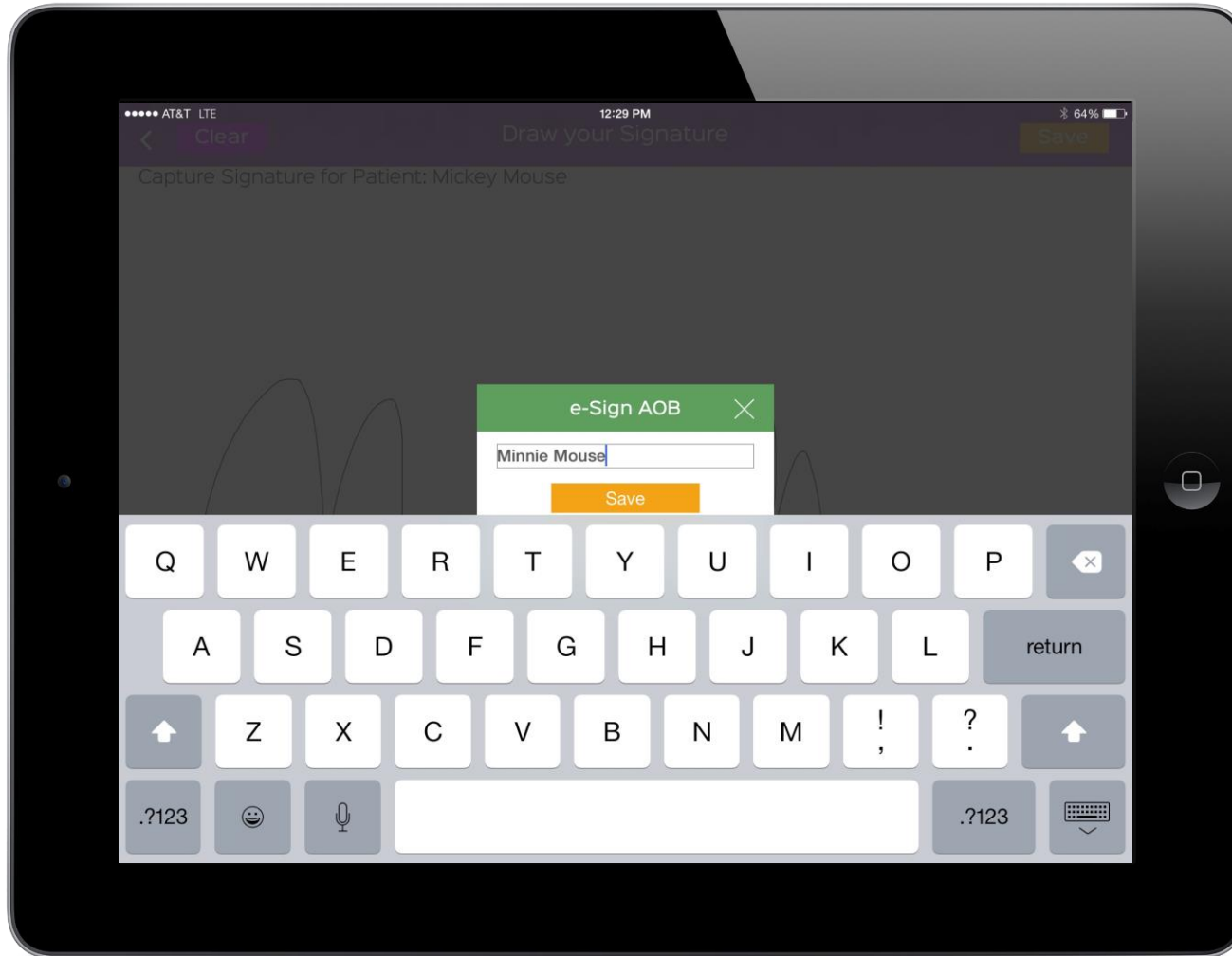
## e-Sign Clicked: Have Patient Sign Device



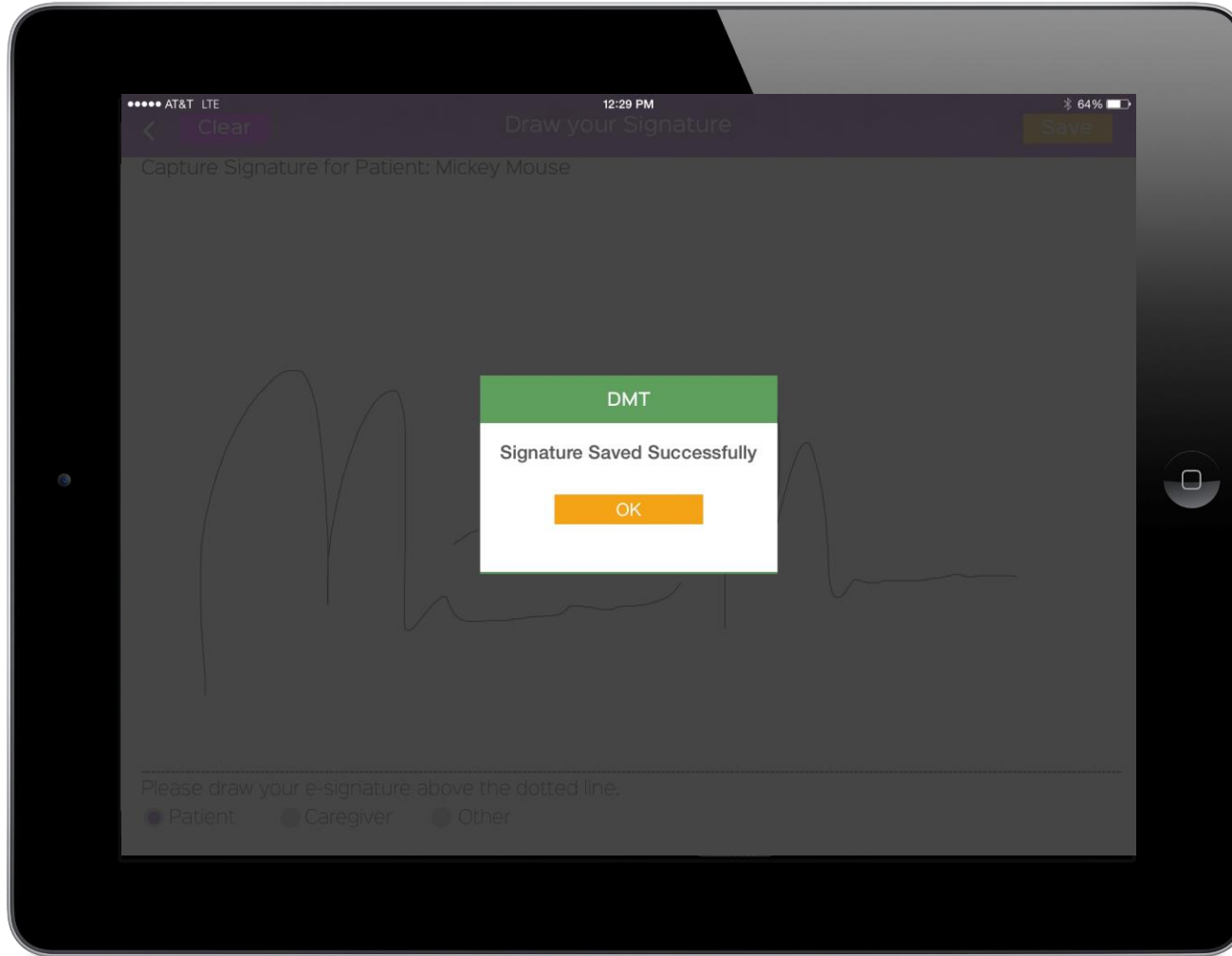
**If Caregiver or Other is selected, type person's name who is signing**



## Sample Screen for Typing Other/Caregiver Name



## “Save” Clicked: e-Sign Successfully Saved & PDF Created





## “AOB” Clicked from Patient Screen: Sample of AOB when viewed from app or web portal

AT&T LTE 12:30 PM 64%

AOB

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Medicaid does not cover this test and the patient will be billed at the private pay rate. If the patient has a financial hardship, please include the hardship waiver for this charge to be waived for the patient.

Some Secondary Insurance Companies do not cover this service which the member will be responsible from the amount left from Primary Insurance. Typical copays/coinsurances are in the range of \$5 - \$15.

**Authenticity Statement, Assignment of Benefit & Medical Release**

I, the undersigned, also certify that I am the recipient of the oximetry testing unit and that the test was actually performed on me at the dates and times specified below. I also certify that I have not, nor has the courier of this test, tampered with or altered this test in any way and that it will be downloaded in its original form.

Pulse Oximeter SN#: \_\_\_\_\_ Date & Start Time: 1/26/2015 2:59:59 PM Date & End Time: 1/26/2015 3:01:39 PM

I, the undersigned, hereby authorize payment be made on my behalf to the organization listed at the top of this page for authorized insurance benefits, including Medicare, if I am a Medicare beneficiary. I understand that I am financially responsible to the organization for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand by signing below, that I am accepting financial responsibility as explained above for all payment for products and or services received.

I, the undersigned, authorize the organization at the top of this page to use and disclose my health information for the purpose of treatment, obtaining payment or supporting the health care operations of my ordering physician. I also authorize the organization at the top of this page to use facsimile with confidential disclosure of my results to my ordering physician and the DME provider listed above. (Note: You may call us using the number above if you would like to review our Notice of Privacy Practices before signing below.)

X \_\_\_\_\_  
Patient / caregiver / Power of Attorney Signature

Electronically signed on 11/11/2015 at 12:20:39

Print Name (If other than patient & mark relationship to patient) \_\_\_\_\_ Relationship with patient:  Caregiver  POA  Relative

**Fax Completed & signed form to DMT at (866) 737-8950. Questions? Please Call (877) 202-1191.**