Tactile MEDICAL

PATIENT CONSENT

CONSENT FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

– I understand that Tactile Medical (Tactile) originates, collects and maintains paper and/or electronic records describing my Protected Health Information (PHI) such as health history, diagnosis, symptoms, test results, etc. I consent to the use and disclosure of my PHI by Tactile, its staff, and its business associates for treatment, payment and healthcare operations.

– I understand I have a right to request restrictions or revoke any use and/or disclosure of my PHI by Tactile. A detailed description of my rights was provided to me in the Notice of Privacy Practices. This authorization is effective for 5 years unless otherwise provided by law.

– I consent to the release of PHI by Tactile to my healthcare providers and insurance company(ies). I authorize and consent to the release by my healthcare providers to Tactile and any insurance company(ies), all PHI necessary to secure payment.

– I understand Tactile may desire to review de-identified health information for the purposes of clinical research, evaluation of patient outcomes, or clinical protocol development. I consent to the release and use of my de-identified information so long as Tactile ensures that I cannot be identified through release and use of that information.

ASSIGNMENT OF BENEFITS

I assign payment of medical benefits to Tactile and direct any payer to make payment on my behalf directly to Tactile. I understand that all costs not covered by my insurance are my responsibility. I understand that in the event my insurance company makes payment directly to me for the medical equipment provided by Tactile, I am responsible for ensuring payment in full is made promptly to Tactile.

CONTACT INFORMATION

Preferred language (if other than English): _____

Best number(s) to contact:

Home (_____)_____ Cell (_____)_____ Work (_____)_____

Email address: _____

By providing my email above, I authorize Tactile to email me regarding my order or other services or products provided by Tactile. I understand that emails containing PHI will be encrypted. Encrypted email will require that I click on a provided link and create a password in order to review the secure email.

ALTERNATE/EMERGENCY CONTACT(S)

I authorize Tactile to contact or respond to inquiries from the following individual(s):

NAME	RELATIONSHIP	PHONE
NAME	RELATIONSHIP	PHONE

MEDICARE BENEFITS

Do you have Medicare?

☐ Yes ☐ No

PRIMARY ADDRESS

My address is a:

☐ Private home/apartment ☐ Assisted Living ☐ Skilled Nursing ☐ Group Home

PATIENT SIGNATURE

By signing this, I agree to all the terms and conditions listed above.

PATIENT NAME (PLEASE PRINT)	PATIENT SIGNATURE	DATE
IF APPLICABLE: NAME OF AUTHORIZED PERSON AND DESCRIPTION OF AUTHORITY TO SIGN; E.G., POWER OF ATTORNEY, LEGAL GUARDIAN (PLEASE PRINT)	AUTHORIZED PERSON SIGNATURE	DATE

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