ACKNOWLEDGEMENT OF GOOD FAITH ESTIMATE AND FINANCIAL RESPONSIBILITY

Today you are receiving a Durable Medical Equipment device from OAW. Our facility will file a claim with your insurance company as a courtesy.

By signing below, you are acknowledging our staff has taken measures to make a good faith estimation of the contracted amount for this device. Because the contracted amount discussed is an estimate of your insurance contract, it could be subject to change without our knowledge. If the rate determined by your insurance is different than what was estimated at the time of fitting, you will be financially responsible for any remaining amounts. If an overpayment is collected, this amount can be applied to any OAW services that have open balances on your account (office visits, MRI, therapy, etc.).

Not all DME services are a covered benefit in all contracts. If your insurance denies the device, you may be financially responsible for the full charge-out amount.

Some items are considered self-pay/retail and are not covered by insurance or billed from this facility. By signing below, you agree to pay in full for these items and understand they will not be billed to your insurance.

Please note we do not take returns or exchanges due to the intimate nature of our products. A one-time exchange will be provided for any product deemed defective under the manufacturer warranty guidelines (not including normal wear and tear).

PATIENT MRN: _____

PATIENT NAME: _____

PATIENT SIGNATURE: _____ DATE: _____

RELATIONSHIP (if patient is a minor or cannot sign on their own): _____

Pewaukee Brookfield Mukwonago