Rider Mobility Inc
3985 West Cheyenne Ave. Suite 306
North Las Vegas, NV, 89032
PH (702) 272-0230
FX (702) 272-0289



# Electronic Signatures

Signature:

I agree to execute the following documents and/or identified categories of documents as an electronic signature (e-signature) as necessary to process the beneficiary's medical equipment or supplies order. The documents subject to this consent include, but are not limited to, the Medical Release, Consent to Process, Delivery Ticket and associated delivery documents, and all subject delivery and terms and conditions of acceptance documents. All electronically signed documents are stored and found in the Customer Access Portal. A hard copy is available upon request. This consent is valid for two years from the effective date.

Beneficiary / Representative Signature: ---------- Date:

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# Patient Acknowledgement & Medical Release To Obtain Medical Records

| Patient Info |
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Release Info:

I hereby authorize and request the release of my Personal Health Information (PHI) by in addition to any other of my medical care providers, emergency contact person/s, hospitals facilities or other third party institutions to Rider Mobility Inc for the purpose of providing Durable Medical Equipment and/or Supplies as follows:

| | |
| --- | --- |
| Entire record: | ☒ |
| Entire record *except*: | ☐ Mental health records |
| | ☐ Communicable diseases (including HIV and AIDS) |
| | ☐ Alcohol / drug abuse treatment |
| | ☐ Other: |

- I understand this consent is effective on the date I sign it. It may be revoked at any time by delivering written notice to Rider Mobility Inc 3985 West Cheyenne Ave Suite 306 , North Las Vegas, NV 89032 and the revocation will be effective as of the date received, except to the extent Rider Mobility Inc has taken action in reliance of this consent.
- This consent is valid for one year from the effective date.
- Information disclosed pursuant to the authorization may be redisclosed by the recipient and no longer protected by the federal privacy regulations
- I understand that I have the right to refuse to give this consent and that Rider Mobility Inc will not condition treatment on obtaining this consent, however, I also understand that most payers require written documentation of my medical condition to authorize payment for Durable Medical Equipment and Supplies.
- I acknowledge that I have received a copy of the Provider Notice of Privacy Practices as required by the Health Information Portability and Accountability Act (HIPAA). I understand that upon completion of reading the notice, any questions I may have may be addressed to the Provider Privacy Officer.
- I acknowledge that I am in receipt of Rider Mobility Inc Patient Information Handouts which include, but are not limited to: Medicare Supplier Standards, Patient Rights and Responsibilities, Complaint procedure, Emergency Planning Guide, Scope of Services and Hours of Operation. These documents have been reviewed with me and I understand their contents.
- I authorize the release of any pertinent information necessary to process this claim I also authorize payment of government benefits either to myself or the party who accepts assignment.
- I authorize Rider Mobility Inc to contact me by telephone concerning the servicing of this product or any other covered or non-covered item.
- I authorize Rider Mobility Inc to discuss my equipment/supplies needs with the following individual(s):

Beneficiary / Representative Signature: ---------- Date: