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Remington Medical
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CPM PATIENT AGREEMENT FORM

Patient Information

*Required Fields

*Last Name:	*First Name:	☐ *Male	☐ *Female
*Address:			
*City:	*Province: Pick province	*Postal Code:	
*Home #:	Work #:	Cell #:	
*Surgery Date:	Setup Date:	Hospital Discharge Date:	

*CPM Type: ☐ Elbow ☐ Knee ☐ Shoulder ☐ Wrist ☐ Hand ☐ Ankle ☐ Other:

Ordering Physician/Therapist

*Ordering Physician:	Phone #:	*Hospital:
Therapist:	Phone #:	
Diagnosis:		Procedure:

Protocol Information *(Office Use)*

Beginning ROM: Frequency Hours/Day:

Other Instructions:

☐ Left ☐ Right ☐ Bilateral ☐ Per Signed Physician Protocols ☐ Patients specific per Physician Orders ☐ Pre-Op Setup

Equipment Rentals *(Office Use)*

Model: ****Lower***** Serial #:

Estimated # of Rental Days: ☐ 14 days ☐ 21 days ☐ 30 days ☐ Other

*Payment Information

I authorize Remington Medical Equipment Ltd. to utilize my credit card information for any unpaid balance of the above charges. I understand that I will be notified by phone of all charges prior to the use of my credit card. Initials: X

☐ Visa ☐ MasterCard	Credit Card #:	Expiry Date:
Cardholder Name:	Cardholder Phone #:	Billing Postal Code:
☐ Cheque	Cheque #:	Check Amount:

Patient Waiver

Patient knows and understands the following:

• How to operation device	☐ YES	☐ NO
• When to Contact Physician	☐ YES	☐ NO
• How to reach Remington Medical with questions or concerns	☐ YES	☐ NO
• How to call Remington Medical to discontinue Rental	☐ YES	☐ NO

If setup is completed by Remington Representative, the following has been verified:

• Accessibility to Hand Controller	☐ YES	☐ NO
• Patient is comfortable in device	☐ YES	☐ NO
• Device is in good working condition	☐ YES	☐ NO

Initials: X

Privacy Act

We understand that health information is personal and must be protected, therefore for these reasons, Remington will:

- provide the highest level of confidentiality in the collection, use and disclosure of your personal health information;
- collect only necessary information to be used solely for the care and treatment you are seeking;
- disclose only information necessary for the delivery and management of your care to those involved in that care. This could include a health care provider or your health insurance plan;
- request permission before disclosing any information for purposes not directly related to your care or treatment, unless otherwise stated by law;
- recognize your right to access your health information when requested and provide copies for a minimal fee;
- dispose of your information in a safe and quick manner, when it is no longer needed or required by law; *and*
- be available to respond to your questions or concerns about the way we handle the privacy of your personal health information.

Terms & Conditions

I,_____, acknowledge that I have the understanding on how to properly operate the device. I agree to permit Remington Medical Equipment Ltd. to obtain my personal health information for use in Health Care Operations, including payment of claims, obtaining information from my designated health care provider, and/or for quality assurance/improvement purposes. I understand that I am responsible for all charges that occur until proper arrangements have been made for the equipment pickup. For rental equipment, I understand how to make arrangements for equipment return and if equipment is damaged, lost, mislaid, stolen or destroyed; I am responsible for the repair charges or the purchase price, whichever is less. I also understand that I am responsible for co-insurance, deductible and non-covered amounts determined by my insurance plan. I have read and agree to the terms and conditions stated above.

Patient or Authorized Representative Signature: X Date: