

Updates have been made on two pages of the Patient Agreement PDFs to align with the new Product Dispense Date feature and to simplify the documents.

Assignment of Benefits/Rx Page / Top Section

1. Decreased the font size of the Patient Product Agreement wording and removed 'and Rx' as not all pages are considered the prescription.
2. Moved Patient and Provider information into the grey header.
3. Removed Injury, Surgery, and Limb fields as they are included on the Demographics page and not needed for the AOB/Rx.
4. Moved Order Date / Prescription Date into this section and Added Product Dispense Date (DOS).

Patient Product Agreement 

Account: DJO - No Testing
Reference Number: 599779 by Cynthia Sever at Sports Orthopedic & Spine - Carlsbad
Billing Address: 123 Main Street



Parent company of DJO, LLC, Surgi-Care, Inc., and Ortho Pros Express, Inc.

Patient - Bob Lawblaw 

Birthdate 2016-02-07 (YYYY-MM-DD)

Length of Need



Products

Provider - Doctor Abductor (1770140113)

ICD-10 Diagnoses

W55.01XA

Order Date / Prescription Date

2024-07-05

Product Dispense Date (DOS)

2024-07-05

ID	Item #	Name	Sizes	Bill Charge	Dispensing Location
5162	01EF-M	DJO - Aircast AirSelect Right	Size: Medium	\$428.00	Account # 9999999999 DJO - No Testing Sports Orthopedic & Spine - Carlsbad 230 Main Street, Suite 200, Carlsbad, CA 92009 888-225-4398

Qty. of Items Ordered: 1

Assignment of Benefits/Rx Page / Bottom Section

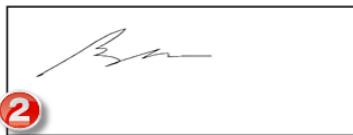
1. Increased the size of the font and text box of the Patient Acknowledgement section.
2. Removed Date and Timestamp from patient signature.
3. Moved the provider signature box to be in line with the patient signature, moved the Order Date / Prescription Date, and removed the provider signature wording.

Patient Acknowledgement 1

PATIENT ACKNOWLEDGEMENTS AND AUTHORIZATIONS: By signing below, I authorize DJO, LLC, Surgi-Care, Inc., Ortho Pros Express, Inc., as well as other direct or indirect DMEPOS supplier subsidiaries of Enovis Corporation (collectively known as "Enovis"), or the Contract Supplier (for Medicare beneficiaries only), to submit a claim on my behalf to my insurer. I also agree to assign the benefits payable by my insurer for such product(s) and services to Enovis or to the Contract Suppliers. It is my responsibility to notify Enovis or the Contract Supplier of any applicable insurance coverages I have, as well as the order in which my insurer(s) should be billed. I authorize Enovis, or the Contract Supplier, to release any of my medical information required by my insurer to process the claim. I understand there is no guarantee of payment by my insurer. If my insurer fails to pay Enovis or the Contract Supplier in full, I agree to pay all unpaid balances. I further understand it is solely my responsibility to contact my insurer if I have any questions about my financial obligations for the product(s) and services provided by Enovis or the Contract Supplier and that any patient responsibility amount provided to me by Enovis, its representatives, or the Contract Supplier is an ESTIMATE only. If litigation is instituted to collect any unpaid balance, I agree to pay all costs, including reasonable attorney's fees, incurred by Enovis or the Contract Supplier. I also hereby grant permission to Enovis, its contractors, or the Contract Supplier to contact me via email, text message, mobile phone, or phone to discuss my outstanding balance or to obtain additional information needed to submit a claim. These contacts may be made during a convenient time to me (i.e., after 8:00 a.m. and before 9:00 p.m. my local time), unless I indicate another time span in which to be contacted. If I wish Enovis, its contractors, or the Contract Supplier to cease any further communications with me via email, text message, mobile phone, or phone about my outstanding balance/debt, I understand I must provide written notice to Enovis at the following address: 2900 Lake Vista Drive, Suite 200, Lewisville, TX 75067.

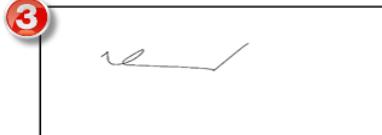
I also acknowledge and understand that Enovis or the Contract Supplier are the provider of the product(s) prescribed by my physician. I authorize Enovis or the Contract Supplier to instruct me on the proper care, use, handling, safety, storage, and disposal of the product(s) that I have received. I understand I must contact my physician for any questions or concerns related to my medical care. I have been provided with access to and understand the Patient Bill of Rights and Responsibilities, the CMS Medicare Supplier Standards, and the Enovis Notice of Privacy Practices. I also have been given the patient manual, product warranty, package insert, return and exchange information about my product(s), as well as instructions on how to contact Enovis if I have questions or concerns.

Patient or Guarantor's Signature



Electronically signed by Bob Lawblaw 2

Provider's Signature



Electronically signed by Doctor Abductor 3

Demographics Page of Billing Document / Top Section

1. Added Order Date / Prescription Date, and Product Dispense Date (DOS) fields.

Patient Product Agreement

Account: DJO - No Testing
 Reference Number: 599779 by Cynthia Sever at Sports Orthopedic & Spine - Carlsbad
 Billing Address: 123 Main Street



Parent company of DJO, LLC, Surgi-Care, Inc., and Ortho Pros Express, Inc.

Patient Information		Medical Information	
Name	Bob Lawblaw	Provider (NPI)	Doctor Abductor (1770140113)
Gender	Male	ICD-10 Diagnoses	W55.01XA
Birthdate	2016-02-07 (YYYY-MM-DD)	Order Date / Prescription Date	2024-07-05
Medical Record #		Product	2024-07-05
		Dispense Date (DOS)	
Phone	760-727-1280	Injury Date	
Mobile Phone	760-727-1280	Surgery Date	
Email	cynthia.sever@djoglobal.com	Length of Need	
Address	1430 Decision St., Vista, CA 92081	Limb	
Emergency Contact		Rental Cycle Days	
Emergency Phone	7607271280		