



**ACCUCARE HOME MEDICAL NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

**I ACKNOWLEDGE UNLESS I AUTHORIZE IT, NO ONE WILL RECEIVE MY MEDICAL INFORMATION OR PHI WITH THE EXCEPTION OF THOSE INSTANCES PROVIDED IN THE "NOTICE OF PRIVACY PRACTICES" AND OF THE PERSON(S) LISTED BELOW. I ALSO, BY SIGNING BELOW, ACKNOWLEDGE RECEIPT OF ACCUCARE HOME MEDICAL'S NOTICE OF PRIVACY PRACTICES.**

I AUTHORIZE THE FOLLOWING PEOPLE TO ACCESS MY MEDICAL INFORMATION:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_\_\_  
**Patient or Responsible Party Signature** \_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Patient or Responsible Party Printed Name**



### HIGHLIGHTS OF ACCUCARE'S AUTOPAY PROGRAM

- Your invoice will be sent 20 days prior to your credit card being charged so you can review prior to payment
- We accept, via our AutoPay program, Visa, MasterCard, American Express, Discover, Care Card, FSA and HSA account cards
- You can manage your account at any time by setting up an online account at: [www.Accucare-inc.com](http://www.Accucare-inc.com)

Cardholder Name: \_\_\_\_\_  
Account Number: \_\_\_\_\_  
Exp. Date: \_\_\_\_\_ CVV Code: \_\_\_\_\_  
Billing Address: \_\_\_\_\_  
Billing City: \_\_\_\_\_ Billing State: \_\_\_\_\_  
Billing Zip: \_\_\_\_\_

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You authorize regularly scheduled charges to your credit card. A charge will appear on your bank/credit card statement as an "ACH Debit". Your auto payment will always be on time, eliminating the possible late charges and preventing collections activity on your account. I understand this authorization will remain in effect until I cancel in writing at least 15 days prior to the next billing date or Return of the rental equipment to Accucare. In the case of a Declined Transaction, I understand Accucare may attempt to process the charge again within 30 days, and agree to an additional \$25 charge for each attempt due to Decline Transactions from my credit card due to insufficient funds or other issues not related to Accucare. I certify I am an authorized user on this credit card and will not dispute these scheduled transactions with my bank or credit card company; so long as the transactions correspond to the terms indicated in this authorization form.

Patient Name (Printed): \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_  
Signature: \_\_\_\_\_

You can see your account details, choose invoicing options (paper statements or eDelivery), and manage your payment options by setting up your profile at [www.Accucare-inc.com](http://www.Accucare-inc.com). You can also call Accucare at (828) 236-3100 between the hours of 8:30am – 5:00pm, Monday-Friday to speak to a customer service representative.

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