



SERVICE AGREEMENT

5 Rockhill Road, Suite 2
 Cherry Hill, NJ 08003
 (800) 800-4276
STOP DATE HOTLINE #222

PATIENT INFORMATION			SUBSCRIBER INFORMATION / BILL TO		
Name (First) (MI) (Last)			Name (First) (MI) (Last)		Relation to Insured
Address			Address		
City		State	Zip	City State Zip	
Phones (Home)		(Other)		Phone (Home) (Work)	
DOB:	SSN: XXX-XX-XXXX	Sex:		DOB:	SSN: XXX-XX-XXXX
EMPLOYER			EMPLOYER		

PRIMARY PAYER

<input type="checkbox"/> Private Insurance	<input type="checkbox"/> Medicare	<input type="checkbox"/> TP Liability	<input type="checkbox"/> Work Comp	DOI: _____	<input type="checkbox"/> Private Pay	<input type="checkbox"/> Other
Payer Name:			Contact:		Phone :	
Address:			City:		State: Zip:	

SECONDARY PAYER

<input type="checkbox"/> Private Insurance	<input type="checkbox"/> Medicare	<input type="checkbox"/> TP Liability	<input type="checkbox"/> Work Comp	DOI: _____	<input type="checkbox"/> Private Pay	<input type="checkbox"/> Other
Payer Name:			Contact:		Phone :	
Address:			City:		State: Zip:	

Services (PATIENT IS RESPONSIBLE FOR COPAY AND DEDUCTIBLE ACCORDING TO THEIR CONTRACT WITH INSURANCE CARRIER.)
 (NOTE: PRIMARY MAX BENEFITS: _____ and SECONDARY MAX: _____)

Item #	Asset #	Description of Services and Estimated patient \$ Responsibility	InsResp	PatRsp	Deduct

Health Plan: Waiver of Liability - Insurance Coverage Notice to Patient

JACE, in accordance with Medicare, Medicaid and other applicable health plans, hereby advises the Customer that the services being provided may not be covered under such plans. By signature below, the Customer agrees to be fully responsible for the charges incurred under this agreement. The reason(s) for this lack of coverage is detailed below:

- Diagnosis or surgery does not qualify for coverage
- Service(s) are not a program benefit
- Service(s) are beyond quantity allowed
- Service(s) did not begin within the specified time
- Other:

Customer Signature → _____

ASSIGNMENT OF BENEFITS: I hereby authorize JACE Systems (JACE) to request on my behalf and to collect directly all insurance benefits due to me by reason of the purchase or rental of the services, equipment and supplies from JACE. In the event that any payments due JACE under this assignment are received by me, I hereby agree to endorse such payment and forward them directly to JACE (checks should be signed on the back and followed by "Pay to the order of JACE"). All costs of the services, equipment and supplies provided to me by JACE which are not paid by my insurance company will become my responsibility. I further authorize the release of any medical information required to process an insurance claim on my behalf, any audit of such claim or as may be requested by any accrediting agency. I also understand that if I am renting this device it will remain the property of JACE and I am responsible for its timely return to JACE upon completion of my treatment program. Sale items can not be returned. JACE Systems can not credit or authorize the return of any sale unit that has been worn after the initial application. We strongly urge you to trial fit all sale items. **PATIENTS ARE RESPONSIBLE TO CALL THE JACE STOP DATE HOTLINE WHEN FINISHED WITH THE UNIT AT 800-800-4276 X222.....OPEN 24 HOURS 7 DAYS A WEEK**

				I received a copy of the "Notice of Privacy Practices" of JACE Systems, my Rights and Responsibilities as a patient, List of services JACE Systems provides, Survey Form, Contact Information for Complaints, Written Instructions on the Unit and DMEPOS Suppliers Standards if applicable.	
Patient / Customer Signature		Date	JACE Representative Signature		Date
Parent / Guardian or Guarantor		Date			

Patient Initials:	
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