VIRTUOX

No cost software + low cost oximeters =
The industry's most cost effective way to qualify oxygen patients!

Patient Name: ________________________________ **DOB:** ________________ **DME Name:** ___________________________

Reading ID: __________________

Assignment of Benefits / Release of Medical Records:
VirtuOx is a CMS approved Independent Diagnostic Testing Facility (IDTF) that performs Overnight Oximetry Testing through a web based technology platform. Your local oxygen supplier is the courier of the oximeter to and from your home. A copy of the overnight oximetry results will be faxed to your physician. Should you have any questions, contact our customer service at (877) 337-7111. The undersigned, understands and agrees that the overnight oximetry test just performed or that I am about to perform was ordered for me by my physician for the purposes of measuring my blood saturation levels and verifying my need for home oxygen as it pertains to my pulmonary disease or condition. Further, I hereby authorize VirtuOx, Inc., to bill my insurance carrier or Medicare on my behalf for the costs of this test. I understand that I may be financially responsible for a deductible or copay and agree to make such payment if it is determined that my deductible or copayment has not been met at the time of billing. If I am deemed ineligible by Medicare or other insurance carriers to which VirtuOx, Inc. submits a claim on my behalf, then I understand that I may be billed. I certify that I am the recipient of the testing described herein and that the test was actually performed on me and that I was awake during the first ten minutes of this test I also certify that the DME supplier who delivered the testing device (oximeter) did not administer the test for me, nor instruct me on how to do so. An informational sheet was left with me containing instructions on how to perform the test, as well as contact information for VirtuOx, Inc., in the event that assistance was needed. I hereby authorize VirtuOx, Inc., to release information concerning this test and any medical information necessary to the provider(s) of my medical care. This authorization will expire 90 days from the signature date and can be cancelled in writing at any time.

AUTHORIZATION TO DISCLOSE HIPAA PROTECTED HEALTH INFORMATION
I authorize VirtuOx, Inc., who will be processing the data from my oximetry reports, to release the report(s) to my physician who ordered the test and to the DME who delivered the equipment. I understand that if information is disclosed under the authorization to someone who is not a health care provider, the information may no longer be protected by federal privacy rules and could be disclosed to others by the recipient. I also understand that I have the right to revoke this Authorization at any time, except to the extent that VirtuOx, Inc., has taken action in reliance on the Authorization, by delivering or sending written notice or revocation to VirtuOx, Inc.

Notice of Privacy Practices
You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our notice provides a description of our treatment, payment activities and healthcare options of the uses and disclosures we may make of your protected health information, and of other important matter about your protected health information. Below is a Notice of this Consent in which we encourage you to read it carefully and completely before signing.

Privacy Notice
Please note that we maintain paper & electronic files that may contain private information about you that may include, but are not limited to your name, address, phone number, contact person, height & weight, diagnosis, prognosis, physician's prescriptions, plans of services & treatment, vital signs, clinical impressions, insurance coverage(s), equipment rented & purchased from us, credit card number, dates of services, etc. We release, transfer & disclose the above information to the third parties to facilitate appropriate provision & review of services & billing for our clients of record. These files are legal documents & are also used for education, evaluating the performance of our organization, marketing & planning purposes. We have measures in place to protect patient health information as required by law. These measures include, but are not limited to, security precautions being in place in our building, billing software, transactions of data to third-parties telephonic & wireless communications, maintenance, retention, & destruction of data, etc. You have the right to amend, restrict, revoke consent to release, examine or obtain copies of the data that we have in your file & have released to others upon request. If you have questions concerning any of the above, please contact our Privacy Officer at the telephone number listed above. I have had full opportunity to read and consider of this Consent form and your Notice of Privacy Practices. I understand that, by signing this consent form. I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

As a reminder, you must stay awake for the first 10 minutes of this test!

Test date **Patient Signature** **Signature date**

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Please print up this patients pre-populated VirtuOx Cover Page

Please fax Cover Page / AOB to **888-295-2922**

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