For Internal Use Only Acct:	TEP	CEV	GBL	VC	FOOU	SC	FV	TS

Consent Form

To help us provide great customer service and deliver our products directly to you, please complete and return the following.

Patient Information

*Required

First name*	Middle initial	Last name*	Sex* ☐ Male ☐ Female

Street*	City*	State*	Zip Code*	Country*

Telephone*	Email	Medicare ☐ Yes ☐ No	Language Preference (if not English) ☐ Spanish ☐ Other ______

Date of Birth (MM/DD/YYYY)	Date of Surgery (MM/DD/YYYY)*	Hospital of Surgery	Puncture Date (MM/DD/YYYY)

Voicing Methods
☐ Provox prosthesis ☐ Esophageal speech ☐ Electrolarynx ______
☐ Other prosthesis ☐ Hands-free ☐ Other ______

Caregiver Name ☐ Spouse ☐ Sibling ☐ Child ☐ Friend	Best Time to Contact ☐ 8am-11am ☐ 11am-4pm ☐ 4pm-7pm
Caregiver Telephone*	Caregiver Email
Clinician Name	Hospital / Clinic Name
Clinician Telephone	Clinician Email

Consent and Privacy Statements

By checking the box below and signing this form, you are agreeing to receive telephone communications from Atos Medical, Inc. at the telephone number you have provided and for marketing purposes would like to receive emails with coupons, promotions and product updates from Atos Medical Inc. Please notify us if you do not wish to receive such communications and we will not use or disclose your information for these purposes. You, as the patient, have the right to choose the durable medical equipment ("DME") supplier from which you obtain all necessary DME items. It may be necessary to select a particular DME supplier specific to your insurance or health plan coverage. You have the right to use the Internet or other sources to identify your DME supplier of choice.*

Atos Medical Inc. respects the privacy of your personal information and will protect the confidentiality of the information contained on this form. Atos Medical Inc. is a Covered Entity under HIPAA and complies with all HIPAA privacy and security regulations. Accordingly, Atos Medical Inc. will only use or disclose your information in the ways outlined in our Notice of Privacy Practices, which may be found online at www.atosmedical.us/privacy-policy-3. If you do not wish to receive communications from Atos Medical, please contact us at 800.217.0025 or email us at info.us@atosmedical.com to request that communications be discontinued. Regular text messages and emails are not secured by a technical process called encryption, so there may be some level of risk the information could be read by someone besides you.

Check ☐	Patient Signature	Date

For Clinician Use Only

I certify the medical necessity of this item for this patient. This section of the form and any statement on my letterhead attached here has been completed by me or by my employee(s) and reviewed by me. The foregoing information is true, accurate and complete and any falsification, omission or concealment of material fact may subject me to civil or criminal liability.

Requests ☐ Welcome Packet ☐ First One's On Us ☐ Clinic Registration / Participation
☐ Coming Home Kit (see alternate delivery address below) ☐ Product ______

Product Dispensed ☐ Other Inv ☐ TSM Inv	REF#	LOT#
Product Dispensed ☐ Other Inv ☐ TSM Inv	REF#	LOT#

Notes

Alternate Ship To Name (if different name/address than patient above, all details are required)*

Street*	City*	State*	Zip Code*	Country*

Clinician Signature	Date

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Atos
Atos Medical Your voice

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