

ASSIGNMENT OF BENEFITS

I, _____, understand and agree that my physician has ordered an oximetry test for the purpose of verifying my need for home oxygen as it relates to an existing or possible pulmonary disease. I hereby authorize and release ASPEN MEDICAL, to bill my Medicare on my behalf for the cost of this test. I understand that I may be financially responsible for any deductible or co-payment and agree to make such payment if it is determined any is due at the time of billing. I authorize ASPEN MEDICAL to release information concerning this test and any medical information necessary to inform the provider(s) of my medical care of results of testing.

MEDICAL RELEASE

I hereby release my medical record, which contains oximetry results to my prescribing physician. I also release my medical record to the homecare provider that delivered the oximeter. My signature on this form gives the right to release these test results to the company/person listed below.

Information to be released to: Company/Individual

Name	Phone
Address	Fax

Patient's Signature	Date
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STATEMENT OF AUTHENTICITY

By signing below, I certify that I am the recipient of the oximetry testing and that the test was actually performed on me. My identity was verified by the provider. I also certify that neither I nor the provider of this test has tampered with or altered this test in any way and that it will be downloaded in its original form.

Patient's Signature	Date
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DIARY OF ACTIVITIES

PATIENT NAME: _____ DATE: _____

PERFORMED ON: _____ ROOM AIR or _____ OXYGEN @ _____ LPM

Time	(Circle One)	Activity Description
____:____	AM OR PM	_____ Time Test Started _____
____:____	AM OR PM	_____
____:____	AM OR PM	_____
____:____	AM OR PM	_____
____:____	AM OR PM	_____
____:____	AM OR PM	_____
____:____	AM OR PM	_____
____:____	AM OR PM	_____
____:____	AM OR PM	_____ Time Test Ended _____