



Patient Consent

Consent for the Use and Disclosure of Protected Health Information

I understand that Tactile Systems Technology, Inc. (Tactile) originates, collects and maintains paper and/or electronic records describing my Protected Health Information (PHI) such as health history, diagnosis, symptoms, test results, etc. I consent to the use and disclosure of my PHI by Tactile, its staff, and its business associates for treatment, payment and health care operations.

I understand I have a right to request restrictions or revoke any use and/or disclosure of my PHI by Tactile. A detailed description of my rights was provided to me in the Notice of Privacy Practices.

I consent to the release of PHI by Tactile to my health care providers and insurance company(ies).

I authorize and consent to the release by my health care providers to Tactile and any insurance company(ies), all PHI necessary to secure payment for the Flexitouch® system (Flexitouch).

Consent to Assist

I understand that Tactile will take the necessary steps to secure authorization and payment for the Flexitouch on my behalf. I agree to cooperate with that process, including using the Flexitouch as prescribed. In the event that Tactile is unable to obtain authorization and payment for the Flexitouch, I understand Tactile will contact me regarding options for obtaining the Flexitouch.

Assignment of Benefits

I assign payment of medical benefits for the Flexitouch to Tactile and direct any payer to make payment on my behalf directly to Tactile. I understand that all costs of the Flexitouch not covered by my insurance are my responsibility.

Consent to Leave Messages

I authorize Tactile to leave voice mail messages for me regarding medical and/or billing information at the following number(s):

(_____) _____ (_____) _____

I authorize Tactile to leave messages with or respond to inquiries from the following individual(s):

_____	_____	_____
Name	Relationship	Phone
_____	_____	_____
Name	Relationship	Phone

I do not authorize Tactile to leave voice mail messages containing medical or billing information.

I authorize Tactile to contact me by email regarding the Flexitouch: _____
Email Address

By signing this, I agree to all the terms and conditions listed above.

_____	_____	_____
Patient Name (Please print)	Patient Signature	Date
_____	_____	_____
Guardian Name (If applicable, please print)	Guardian Signature	Date

Please return completed form to Tactile Systems Technology, Inc.
Mail: 1331 Tyler Street NE, Suite 200, Minneapolis, MN 55413 **Fax:** 866.435.3949
To speak with a Patient Services representative, call toll-free: 866.435.3948



TACTILE SYSTEMS TECHNOLOGY INC.

1331 Tyler Street NE, Suite 200
Minneapolis, Minnesota 55413

TEL: 866.435.3948
FAX: 866.435.3949

Hours of Operation
Monday-Friday 8 a.m. to 5 p.m. CT

www.flexitouch.com