Completed Durable Medical Equipment Packet must have the following items:

- ☐ A medical script stating the need for the durable medical equipment
- ☐ The signed Durable Medical Equipment Agreement
- ☐ The signed MS Release of Information

*Note: Durable Medical Equipment Packet may be can be sent to our office at National MS Society, 7611 State Line Road Ste 100 Kansas City, MO 64114, faxed to 816-343-0319, or emailed to Megan Lyons at mlyons@nmsskc.org.

National
Multiple Sclerosis
Society
Mid America
Chapter

Mid America Chapter
7611 State Line Road
Suite 100
Kansas City, MO 64114
913-432-3926
816-343-0319 - Fax

DURABLE MEDICAL EQUIPMENT AGREEMENT

By agreement with the National Multiple Sclerosis Society, Mid America Chapter, Inc. and with the consent of my physician (see attached prescription or letter of necessity) I, _____, am the recipient, on this _____ day of _____, 2008, of the equipment described as follows:

_____

_____
(item(s) description, serial number, and MS tag number)

I understand that the above described equipment is the property of the National Multiple Sclerosis Society, Mid America Chapter, Inc., and is on loan to me for my use. I further agree that this equipment cannot and will not be transferred or sold by me and that it is for my use only. I agree that I will take proper care of the equipment while it is in my possession and I have an obligation to return it to the Mid America Chapter in good condition upon expiration of this agreement. I agree to notify the chapter of any change in my address. If I move out of the chapter's area, I will return said equipment to the Mid America Chapter unless written approval is given to me by the Mid America Chapter. All of the above being agreed to, I hereby, for myself, my heirs, executors, and administrators, waive and release any and all rights and claims for damages I may have against the Mid America Chapter or any other persons connected with this program, their agents, representatives and assigns for any and all injuries suffered by or illness to myself resulting from use of said equipment.

Signature:_____
(Recipient)
Date:_____

Signature:_____
(Authorized Mid America Chapter Rep.)
Date:_____

ALL INFORMATION IS CONFIDENTIAL.
(National Multiple Sclerosis Society, Mid America copy)

National Multiple Sclerosis Society
Mid America Chapter
7611 State Line Road, Suite 100
Kansas City, MO 64114

Tel 913 432 3926/ 800 344 4867
Fax 816 343 0319
info@nmsskc.org
www.MSmidamerica.org

National Multiple Sclerosis Society, Mid America Chapter
Release Of Information

I, _____, hereby authorize the National Multiple Sclerosis Society, Mid America Chapter to exchange information regarding (please initial each item you authorize release of information on):

_____ Verification of Diagnosis
_____ Medical Information (e.g., insurance, medication, on-going medical care)
_____ Housing/Home Care Information
_____ Financial Information (e.g., employment, income, assistance programs)
_____ Services provided by the National Multiple Sclerosis Society
_____ Other: _____

To: Organization/Individual Name: _____
Address: _____
_____
Phone: _____

I understand that this information will be kept in a secure and confidential manner by the National Multiple Sclerosis Society staff and volunteers.

I have been informed of my right to refuse to allow the National Multiple Sclerosis Society, Mid America Chapter to exchange this information.

I understand that I may revoke this consent upon written notice to the Care Manager. The revocation will become effective the day it is received by the Care Manager.

I further understand that this consent will automatically expire within one year following the date of my signature, if an earlier date is not specified.

_____
Name (Please print) Date

_____
Signature Date

The National Multiple Sclerosis Society is proud to be a source of information about multiple sclerosis. Our comments are based on professional advice, published experience and expert opinion, but do not represent therapeutic recommendation or prescription. For specific information and advice, consult your physician.