SUPPLIES SHIPPING PROGRAM CONSENT

I, _____, would like Northshore Sleep Medicine to ship my supplies to me and bill my PAP supplies, to my insurance company, according to the following schedule:

I, _____, acknowledge that I will be responsible for my shipping charges.

Return Policy on Shipped Supplies: Due to the sterile and delicate nature of the supplies, we will NOT accept returned supplies after 14 days of shipping. This will give you exactly 14 days to contact our office should changes be necessary in your equipment order. Unfortunately, after that period of time we cannot take returns on shipped supplies.

I hereby agree to the 14 day EXCHANGE or RETURN POLICY on all shipped supplies.

Date: _____

Ship To Information:

First Name: _____ Last Name: _____
Address: _____ Address 2: _____APT#:_____
Suite #: _____City: _____State: _____Zip Code: _____
Phone: _____

ALTERNATE Ship To Information: **From:** _____ **To:** _____

First Name: _____ Last Name: _____
Address: _____ Address 2: _____APT#:_____
Suite #: _____City: _____State: _____Zip Code: _____
Phone: _____

Product Information

Brand and model of PAP machine: _____

Mask: _____ Alternate: _____

Description	Size	NSM Recommends	Max Allowed	Patient Request
Tubing	6ft 8ft	1/ 3 months	1/3 months	
Filter	Non-Disposable	1/ 6 months	1/6 months	
Filter	Disposable	1/3 months	1/3 months	
Cushion		2/ 3 months	2/1 months	
Headgear w/Cushion		1/ 6 months	1/6 months	

_____**DO NOT** ship **Mask with Headgear** on first shipment

First Ship Date:_____

Comments: _____

Signature: _____ Date: _____