Kernel Home Phototherapy
Patient Order Form

Fax To: 214-414-2533 ▪ Email To: sales@dermitech.com

Mail To: PO Box 801403, Dallas, TX 75380-1403

To be filled out by the PATIENT. Please print clearly. For assistance, please call 214-377-8144.

Patient Information

Patient Name____ Date of Birth__________________

Address______________________________ City____________________ State_____ Zip __________

Cellphone_________________________ Alternate Phone ________________________

Email Address ____

Shipping Address (if different from above): I prefer to be contacted via ☐ Email ☐ Phone ☐ Text

Name____

Address______________________________ City____________________ State_____ Zip __________

Product Choice

KERNEL

KN-4003BL2S
Hand-Held Wand
Prescription Model
One 9W Lamp

Includes:
Wand Unit, Eye Goggles, User Manual, 120V AC Adapter/Cord

Durable Medical Equipment HCPCS Code: E0691

Lamp Spectrum: Narrowband UVB (311nm peak emission)

Confirmation

I confirm that the above information is accurate and complete to the best of my knowledge.
I agree to follow my prescriber's instructions for the proper use of this medical device.

It is important to understand the size, weight and electrical requirements of your device. Please discuss these details and any special delivery needs you may have with your Dermitech representative by calling 214-377-8144.

☐ **I have read and agree to the Patient Agreement (required).**

Signature ____ **Date** _____________________

Relationship to Patient: ☐ **Self** ☐ **Parent** ☐ **Authorized Representative**

If Parent or Authorized Rep, please print name ____

If Authorized Rep., reason patient can't sign ____

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Patient Copy

Keep for Your Records!

Patient Agreement

Below are the terms and conditions of sale or evaluation of home medical equipment. Please read carefully and sign the Patient Order Form if you agree. Please call 214-377-8144 if you need assistance or have questions.

- Home medical devices that we sell can only be purchased or evaluated with a valid prescription or written order from a licensed physician per FDA regulations.
- You agree to use your home medical device only in the manner in which it was intended. This includes following your physician's instructions and scheduling periodic follow-up examinations. Minor patients for whom this unit is prescribed are required to be under the supervision of a parent or guardian who understands the use of the device and assumes full responsibility of the minor. You agree to follow all safety precautions, including wearing protective goggles during all home phototherapy treatments.
- Dermitech's HIPAA Privacy Policy, Medicare Standards, Patient Bill of Rights and Scope of Services documents are available at www.dermitech.com, and a printed copy will be included with your device upon delivery. To receive a copy by fax, mail or email, call Dermitech at 214-377-8144.
- There is no obligation to purchase when your insurance benefits and eligibility are verified. However, once you have instructed Dermitech to process your order, payment in full of the agreed upon price becomes your responsibility. You understand that unmet deductibles, co-pays and changes in plan benefits can sometimes affect the amount of reimbursement you receive, and you agree to pay the difference between the agreed upon price and the amount of your insurance reimbursement.
- If your balance due is over 60 days late, a collection company may be used to collect payment. You will be responsible for collection company fees in addition to the balance due.
- If your device has not yet been paid in full and your insurance company sends payment to you instead of to Dermitech, you agree to forward this payment to Dermitech within five business days of receipt.
- Only purchases of new products within the contiguous 48 states qualify for free delivery. Hawaiian and Alaskan deliveries will incur additional shipping charges.
- Large equipment will be delivered to the ground floor door of your home or garage. If you desire additional service, such as a stair carry or transport to the interior of your home, you must make arrangements yourself or contact Dermitech regarding these or other services.
- Upon delivery to your home, you agree to inspect the package and to note any damage on the freight receipt prior to accepting the delivery. If you are unable to fully inspect the equipment before signing off on the delivery, you agree to indicate "Further Inspection Required - Concealed Damage Possible" on the freight receipt and to notify Dermitech within two business days of the product being delivered if any damage is present.
- You agree that you have read and fully understand the size and weight of the device and that you have space to accommodate it. Further, you confirm your understanding that some large devices may require a special electrical outlet that may need to be installed for the device to operate. Information on size, weight and electrical requirements can be found on the equipment supplier's website or you may contact Dermitech at 214-377-8144.
- You agree that purchased prescription medical equipment is non-returnable, therefore all sales are final.
- You understand, as the purchaser, that signing the Patient Order Form document constitutes my understanding and agreement to the terms and conditions contained herein, which are applicable to the purchase of home medical equipment.