Dear Valued Customer,

Thank you for choosing Comfort Medical for your medical supplies! We appreciate your business.

Please take a moment to complete this brief survey so we can continue to improve our service to you. We are dedicated to providing you with 100% customer satisfaction and your feedback is important to us.

In addition, please complete and sign the Customer Account Form on the back. This form acknowledges receipt and understanding of required regulatory notifications and provides a place to update/add account information. Be sure to include your secondary insurance information on the form as this may eliminate any cost to you.

Feel free to call us with any questions or concerns you may have regarding your supplies at

1-800-700-4246.

Welcome, and we look forward to serving you!

Sincerely,
Your Friends at Comfort Medical

Customer Satisfaction Survey

Please circle the degree to which you agree or disagree with the statement.	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
The representative with whom I spoke was courteous and professional.	1	2	3	4	5
The representative explained clearly the mail order program.	1	2	3	4	5
My order arrived when I expected.	1	2	3	4	5
My order contained the supplies I expected.	1	2	3	4	5
I am satisfied with the supplies I received.	1	2	3	4	5
I will continue to order my supplies from Comfort Medical.	1	2	3	4	5
I would recommend Comfort Medical to my friends and family.	1	2	3	4	5
I would order other medical products from Comfort Medical.	1	2	3	4	5

Additional Comments:

Customer Account Form

1-800-700-4246

Instructions:

1. Complete the below sections (only required if your information has changed since our last discussion)
2. Print and sign the bottom of this page
3. Return this form in the pre-paid envelope

Customer Information

Name: ____________________

Phone: ____________________

Email Address: ____________________

Physician Information

Physician Name: ____________________

Phone: ____________________

Primary Insurance Information

Primary Insurance: ____________________

Phone: ____________________

Policy Number: ____________________

Secondary Insurance Information

Secondary Insurance: ____________________

Phone: ____________________

Policy Number: ____________________

By signing below, I acknowledge the following:

- I understand that I can use only one provider for this product category of medical supplies and I have chosen Comfort Medical as my sole provider for this product category. I will inform Comfort Medical promptly if I begin home health services.
- In accordance with its Notice of Privacy Practices, Comfort Medical may obtain medical information necessary in order to process my order, determine eligibility, and seek reimbursement for medical supplies provided to me by Comfort Medical and contact me or my designees to discuss my medical supplies. Comfort Medical may release my medical information to and directly bill Medicare, Medicaid, and/or other insurer(s) and their agents on my behalf for medical supplies provided to me by Comfort Medical.
- I have received the Comfort Medical Welcome Kit including the Customer Rights and Responsibilities, information relating to the Notice of Privacy Practices, the location reference of the CMS Supplier Standards, and other required regulatory notifications. I have read and understand its contents.

Please print your name ____________________

Signature

SIGN HERE

Date

DATE HERE