



### DISCLAIMER OF WARRANTIES:

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I acknowledge and understand that Compression Design has a **NO RETURN POLICY** for this Custom Product. I also understand there is a 10 day policy for reworks. If Compression Design is not notified within 10 days of me receiving the garment(s), a rework fee will be charged.

I authorize any holder of medical information about me to release that information to the Health Care Financing Administration (HCFA) and its agents. This includes any information needed to determine these benefits or the benefits payable for related services. I further permit a copy of this authorization to be used in place of the original.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

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