Patient Enrollment Application

Safe n Simple™ SIMPLESTART™ Ostomy Care

HHA Company Name:_____

WOCN/Nurse Contact Name: _____

WOCN/Nurse Phone:_____Email: _____

Patient Name: _____

Address: _____

City:_____ State:_____ Zip:_____

Phone:_____ Date of Birth: _____

Email: _____

Name of Family Member/Caregiver: _____

Type of Ostomy:_____Date of Surgery:_____ Stoma Size: _____

Product Types in Use: _____

_____

_____

Insurance Carrier Name: _____

As an enrollee in the **Safe n Simple SIMPLESTART Ostomy Care Kit Program**, I agree to allow my personal information to be given to Safe n Simple in order to provide me with products and connect me with a distributor to obtain future supplies.

Date:_____

Patient Authorized Signature:_____

Safe n Simple cares about your privacy and complies with HIPAA requirements. Safe n Simple will not sell, rent, or give your personal information without your permission except where: (1) required by law; or (2) used by Safe n Simple, its agents, affiliates, contractors, or supply or service providers, to provide you with information by telephone, or other methods, about Safe n Simple products, services, and wellness education. Safe n Simple may change this privacy statement from time to time. If you do not wish to continue to receive communication from Safe n Simple, you may opt out by contacting Safe n Simple at 1-844-767-6334 or email simplestart@sns-medical.com.

Fax or email completed application form to: **248-575-4172 Fax** or **SimpleStart@SnS-Medical.com**

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