

**ACKNOWLEDGEMENT OF RECEIPT**

OPTIMAX S4000       MICRO Z       X-CEL 4000       NMES

Patient: \_\_\_\_\_ Physician: \_\_\_\_\_

Patient Phone: \_\_\_\_\_ Serial #: \_\_\_\_\_

Date equipment and/or supplies received: \_\_\_\_\_

I acknowledge I have received the items marked below, provided by Advanced Therapy Concepts, Inc:

- [ ] Optimax S4000 Stimulator
- [ ] Micro Z HVPG Stimulator System
- [ ] X-CEL 4000
- [ ] NMES
- [ ] Lead Wire(s)                      Quantity: \_\_\_\_\_
- [ ] Rechargeable AA Batteries      Quantity: \_\_\_\_\_
- [ ] Disposable AAA Batteries      Quantity: \_\_\_\_\_
- [ ] Battery Charger
- [ ] A/C Wall Adapter
- [ ] Premium reusable electrodes      Quantity: \_\_\_\_\_ (4 pack)
- [ ] Skin protective wipes              Quantity: \_\_\_\_\_
- [ ] Conductive Mist                      Quantity: \_\_\_\_\_
- [ ] Garment(s)                              Quantity: \_\_\_\_\_
- Quantity: \_\_\_\_\_
- [ ] Miscellaneous, Description and Quantity      \_\_\_\_\_
- [ ] Stamped self-addressed envelope to Advanced Therapy Concepts, Inc

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

This form must be signed, dated and returned to Advanced Therapy Concepts, Inc as soon as possible. This form provides **Proof of Receipt** of the equipment and/or supplies as mandated by your insurance company. Failure to return this signed and dated form may result in you being personally responsible for all incurred charges. The form may be returned in one of several ways:

- 1. Mail, with the stamped self-addressed envelope provided initially with your equipment**
- 2. Fax, to our office at 231-882-2376**

If you did not receive all of the equipment and supplies indicated above, please contact our office immediately at 800-864-0293.

**Our office will distribute a monthly supply for those insurance carriers which allow monthly disbursement. If at any time you wish to discontinue or customize your supply shipment, please inform our office at 800-864-0293.**