



# Home Medical Visits

## Diagnostic Medical Testing

Patient's Are Our First Priority

Tel: (877) 202-1191 \* Fax: (866) 637-2890

### PATIENT INFORMATION

PATIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_ CITY/ ST/ ZIP: \_\_\_\_\_  
 PHONE: \_\_\_\_\_ SSN: \_\_\_\_\_ GENDER: M:  F:   
 DME PROVIDER INFORMATION: NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_  
 CITY: \_\_\_\_\_ ST: \_\_\_\_\_ FAX: \_\_\_\_\_

### INSURANCE INFORMATION

PRIMARY INSURANCE:

MEDICARE MEDICARE NUMBER: \_\_\_\_\_  
 MEDICAID MEDICAID NUMBER: \_\_\_\_\_ STATE: \_\_\_\_\_  
 PRIVATE POLICY NUMBER: \_\_\_\_\_ GROUP #: \_\_\_\_\_  
 INSURANCE NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_ CITY / STATE / ZIP: \_\_\_\_\_  
 INSURED PERSON: \_\_\_\_\_ SELF:  SPOUSE:  CHILD:  OTHER:

### ASSIGNMENT OF BENEFITS / STATEMENT OF AUTHENTICITY – REQUIRED

I, the undersigned, hereby authorize payment be made on my behalf to the organization listed at the top of this page for authorized insurance benefits, including Medicare, if I am a Medicare beneficiary. I understand that I am financially responsible to the organization for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand by signing below, that I am accepting financial responsibility as explained above for all payment for products and or services received.

I, the undersigned, also certify that I am the recipient of the oximetry testing unit and that the test was actually performed on me at the dates and times specified below. I also certify that I have not, nor has the courier of this test, tampered with or altered this test in any way and that it will be downloaded in its original form.

TEST DONE ON: <input type="checkbox"/> ROOM AIR <input type="checkbox"/> OXYGEN <input type="checkbox"/> CPAP / BIPAP	TEST STARTED: DATE: _____ TIME: _____	TEST ENDED: DATE: _____ TIME: _____
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**X**

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

### MEDICAL RELEASE:

I, the undersigned, authorize the organization at the top of this page to use and disclose my health information for the purpose of treatment, obtaining payment or supporting the health care operations of my ordering physician. I also authorize the organization at the top of this page to use facsimile with confidential disclosure of my results to my ordering physician and the DME provider listed above. (Note: You may call us using the number above if you would like to review our Notice of Privacy Practices before signing below.)

**X**

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_