

915 S. Orange Ave
Orlando, FL 32806

1113 N. Central Ave
Kissimmee, FL 34741



724 S. Hwy 441
Lady Lake, FL 32159

614 E Altamonte Dr
Altamonte Springs, FL 32701

Account Name _____
CSR _____
Date _____
Referral Source _____

Phone: 407-849-6455
Fax: 407-849-6458

Patient Information Form

Toll Free: 800-747-0246

<p style="text-align: center;">Personal Information</p> <p>Name _____</p> <p>Address _____</p> <p>City, State, Zip _____</p> <p>(Area) Phone _____ Height _____ Weight _____</p> <p>Date of Birth _____ Social Security Number _____</p>	<p style="text-align: center;">Insurance Information (For Office Use Only)</p> <p>Primary _____ (Area) Phone Number _____</p> <p>Address _____ City, State, Zip _____</p> <p>ID# / Member # /Policy # /Claim # _____ Group # _____</p> <p>Adjuster/Contact _____ Date of Injury _____</p>																								
<p style="text-align: center;">Additional Information</p> <p>E-Mail Address _____</p> <p>Cell Phone _____ Work Phone _____</p>	<p>Primary Verification</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td>Date _____</td> <td>Verified by _____</td> <td>Spoke with _____</td> <td>Title _____</td> </tr> <tr> <td>HMO? _____</td> <td>Preferred DME Provider? _____</td> <td colspan="2">If yes, Who? _____</td> </tr> <tr> <td>Effective Date _____</td> <td>DME Coverage? _____</td> <td>%of Coverage _____</td> <td>Copay _____</td> </tr> <tr> <td>Deductible _____</td> <td>Amt Ded Met _____</td> <td>Oop _____</td> <td>Max Coverage _____</td> </tr> <tr> <td>Auth Required? _____</td> <td>Auth # _____</td> <td colspan="2">Expiration Date _____</td> </tr> <tr> <td>Care Coordination Phone _____</td> <td colspan="3">Spoke with _____</td> </tr> </table>	Date _____	Verified by _____	Spoke with _____	Title _____	HMO? _____	Preferred DME Provider? _____	If yes, Who? _____		Effective Date _____	DME Coverage? _____	%of Coverage _____	Copay _____	Deductible _____	Amt Ded Met _____	Oop _____	Max Coverage _____	Auth Required? _____	Auth # _____	Expiration Date _____		Care Coordination Phone _____	Spoke with _____		
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Auth Required? _____	Auth # _____	Expiration Date _____																							
Care Coordination Phone _____	Spoke with _____																								
<p style="text-align: center;">Emergency Contact/Next of Kin/Primary Caregiver Information</p> <p>Name _____ Relationship _____</p> <p>Address _____ Phone _____</p>	<p>Item Received: _____ Item Covered? _____</p> <p>Product #: _____ SN#: _____</p>																								
<p style="text-align: center;">Physician Information</p> <p>Name _____</p> <p>Address _____</p> <p>Phone # _____ Fax# _____</p> <p>Patient Diagnosis _____ NPI #/Medipass# _____</p>	<p>Secondary _____ (Area) Phone Number _____</p> <p>Address _____ City, State, Zip _____</p> <p>ID# / Member # /Policy # /Claim # _____ Group # _____</p>																								
<p style="text-align: center;">Same/Similar Equipment</p> <p>Have you ever rented or purchased any type of similar equipment in the past? _____ Yes _____ No If yes:</p> <p>1) When? _____</p> <p>2) What? _____</p> <p>3) Payer (insurance or self pay)? _____</p> <p>4) Do you reside in a nursing facility? _____</p> <p>5) Are you receiving Home Health Services? _____</p>	<p>Secondary Verification</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td>Date _____</td> <td>Verified by _____</td> <td>Spoke with _____</td> <td>Title _____</td> </tr> <tr> <td>HMO? _____</td> <td>Preferred DME Provider? _____</td> <td colspan="2">If yes, Who? _____</td> </tr> <tr> <td>Effective Date _____</td> <td>DME Coverage? _____</td> <td>%of Coverage _____</td> <td>Copay _____</td> </tr> <tr> <td>Deductible _____</td> <td>Amt Ded Met _____</td> <td>Oop _____</td> <td>Max Coverage _____</td> </tr> <tr> <td>Auth Required? _____</td> <td>Auth # _____</td> <td colspan="2">Expiration Date _____</td> </tr> </table>	Date _____	Verified by _____	Spoke with _____	Title _____	HMO? _____	Preferred DME Provider? _____	If yes, Who? _____		Effective Date _____	DME Coverage? _____	%of Coverage _____	Copay _____	Deductible _____	Amt Ded Met _____	Oop _____	Max Coverage _____	Auth Required? _____	Auth # _____	Expiration Date _____					
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Auth Required? _____	Auth # _____	Expiration Date _____																							

Release of Medical Records / Patient Affirmation

I hereby give Colonial Medical Supplies Permission to have access from the above listed physician to any medical records that are required by my insurance company to pay for insurance claims. These records should pertain to any treatments past or present that are related to services I am receiving from Colonial Medical Supplies.

I swear that the above information is correct. I understand that I may be financially responsible for services rendered. If the above information is found to be incorrect, or if I do not notify Colonial Medical Supplies in writing immediately if there are any changes in the information I have provided.

I authorize payment of medical benefits directly to Colonial Medical Supplies for equipment and services furnished to me by the company I understand that I am responsible for payment of any charges incurred by me or anyone acting on my behalf if my insurance company refused to pay for any reason which included but is not limited to refusal due to non-coverage or delay due to pending law suits. Any unpaid balances will have a finance charge of 1.5% per month. If account is transferred to collection, beneficiary is responsible for any additional collection costs incurred. Please let associate know if you have any specific needs based on religious or cultural background.

Signature of Client or Authorized Person (Please attach POA or Legal Document Giving Authorization) _____ **Date** _____ **Relationship**