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

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

Account Name_____
CSR_____
Date_____
Referral Source_____

Patient Information Form

Toll Free: 800-747-0246

Personal Information

Name
_____
Address
_____
City, Sate, Zip
_____
(Area) Phone _____ **Height** _____ **Weight** _____
Date of Birth _____ Social Security Number _____

Additional Information

E-Mail Address _____

Cell Phone _____ **Work Phone** _____

Emergency Contact/Next of Kin/Primary Caregiver Information

Name _____ Relationship _____
Address _____ Phone _____

Physician Information

Name
_____
Address
_____
Phone # _____ Fax# _____
Patient Diagnosis _____ NPI #/Medipass# _____

Same/Similar Equipment

Have you ever rented or purchased any type of similar equipment in the past? _____ Yes _____ No If yes:
1) When? _____
2) What? _____
3) Payer (insurance or self pay)? _____
4) Do you reside in a nursing facility? _____
5) Are you receiving Home Health Services?_____

Insurance Information (For Office Use Only)

Primary (Area) Phone Number
_____ _____
Address City, State, Zip
_____ _____
ID# / Member # /Policy # /Claim # Group #
_____ _____
Adjuster/Contact Date of Injury
_____ _____

Primary Verification

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 _____

Item Received: _____ Item Covered? _____
Product #: _____ SN#: _____

Secondary (Area) Phone Number
_____ _____
Address City, State, Zip
_____ _____
ID# / Member # /Policy # /Claim # Group #

Secondary Verification

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 _____

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