Medical Devices Texas, LLC.

Patient Name: _____ DOB: _____/_____/_____

Address: _____

City: _____ State: _____ Zip: _____

Emergency Contact: _____ Phone Number: _____

Physician: _____ Phone Number: _____

Diagnosis: _____

Products Ordered: _____

Medicare Part B Number (If Eligible): _____ Effective: _____

Medicaid Number (If Eligible): _____ State: _____

Other Insurance: _____

Address: _____

Policy Number: _____ Group Number: _____

Policy Holder: _____ DOB: _____/_____/_____

- Insurance payment authorization: I request that Medicare, and/or any other insurance provider that I have, make payments of authorized benefits on my behalf directly to Medical Devices Texas, LLC for equipment/supplies they furnish to me and for which they submit claims on my behalf.
- Release of Insurance information: I request my medical insurance plan(s) to release to the above-named company, any and all information which will assist in processing my claims for medical supplies and/or equipment that I am receiving from the above-named company even after service to me is discontinued. I also authorized any holder of hospital or medical information about me to release to the health care financing administration, its agents, my insurance company or the above-named company any information needed to determine the benefits that are payable for related services.
- I understand if my insurance plan(s) makes payment(s) to me for services and supplies that I have received, rather than directly to the above-named company, I agree to endorse those checks and send them immediately to the above-named company.
- I also understand that I am responsible for the payment of any deductible, co-insurance or of other portion of my charges not paid by my insurance plan(s). I also understand that I may be eligible for a partial or complete waiver of any unpaid co-insurance charges only, under Medical Devices Texas, LLC.
- I hereby agree that Medical Devices Texas, LLC or any of its affiliates may contact me, or my authorized caregiver, by telephone at my place of residence.
- I have reviewed and understand the information above. I have been instructed on and understand the use of the products provided. I have received the products ordered. I have received a copy of a patient handout that contains patient rights and responsibilities, supplier standards, privacy notice and emergency information. I have received the product manual/instructions, warranty information, and instructions to follow up with Medical Devices Texas, LLC.
- I understand that items prescribed for homecare cannot be re-dispensed. Therefore, these items cannot be returned for credit.
- I understand that I may lodge a complaint without concern for reprisal, discrimination, or unreasonable interruption of service.
- Identified needs/problems: The patient was unfamiliar with use of the product(s) provided. Expected outcomes: The patient will be provided with the product(s) to comply with the physician's prescription. The patient will use the product(s) as prescribed by the physician. The patient will know how to obtain follow-up services as needed.

Patient or Responsible Party Signature:	Date:
Witness Signature (IF BENEFICIARY IS UNABLE TO SIGN):	Relationship:
Reason Patient is Unable to Sign:	

Please send completed form to: CAROL@DMETEXAS.COM Or fax to: 346-206-4334

DME Texas
Fortifying Recovery * Innovative Solutions * Lasting Impact