

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;"><b>Personal Information</b></p> <p>Name _____</p> <p>Address _____</p> <p>City, State, Zip _____</p> <p>(Area) Phone _____      <b>Height</b> _____      <b>Weight</b> _____</p> <p>Date of Birth _____      Social Security Number _____</p>	<p style="text-align: center;"><b>Insurance Information (For Office Use Only)</b></p> <p><b>Primary</b> _____ (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;"><b>Additional Information</b></p> <p>E-Mail Address _____</p> <p>Cell Phone _____      Work Phone _____</p>	<p><b>Primary Verification</b></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 _____																							
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<p style="text-align: center;"><b>Emergency Contact/Next of Kin/Primary Caregiver Information</b></p> <p>Name _____      Relationship _____</p> <p>Address _____      Phone _____</p>	<p>Item Received: _____      Item Covered? _____</p> <p>Product #: _____      SN#: _____</p>																								
<p style="text-align: center;"><b>Physician Information</b></p> <p>Name _____</p> <p>Address _____</p> <p>Phone # _____      Fax# _____</p> <p>Patient Diagnosis _____      NPI #/Medipass# _____</p>	<p><b>Secondary</b> _____ (Area) Phone Number _____</p> <p>Address _____      City, State, Zip _____</p> <p>ID# / Member # /Policy # /Claim # _____      Group # _____</p>																								
<p style="text-align: center;"><b>Same/Similar Equipment</b></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><b>Secondary Verification</b></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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**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**