Patient Information

Name Last: _____ First: _____ Middle: _____

DOB: _____ SS#: _____ Email: _____

Home Address: _____

City: _____ State: _____ County: _____ Zip Code: _____

Mailing Address: _____

City: _____ State: _____ County: _____ Zip Code: _____

Phone Home: _____ Cell: _____ How did you hear about us? _____

Referring Doctor: _____Date of last visit: _____ Phone: _____

Emergency Contact

Name: _____ Phone: _____ Relationship: _____

Insurance Information

Primary Insurance: _____ ID: _____

Secondary Insurance: _____ ID: _____

Primary Policy Holder: _____ DOB: _____

Consent for Care/Service: I am informed & aware I may choose where to receive Home Medical Equipment (HME). I authorize SMS to provide HME as prescribed by my physician.

Release of Information: I authorize the release of my medical records, inclusive of all pertinent information acquired during services, to/from SMS, the treating physician, payer sources, and/or other medical providers involved with services as deemed necessary, for the purpose of providing services.

Assignment of Benefits/Financial Responsibility: I hereby authorize payment of all health insurance benefits to SMS and allow assignee to release all information necessary to secure payment. I understand I am responsible for providing my current insurance/payer information to SMS. I agree a photocopy of this authorization shall be considered as effective and valid as the original. I understand I am legally responsible for all charges incurred whether they are paid by my health insurance, or not. Any unpaid balance shall be due in full immediately if insurance proceeds are paid directly to me. Charges that may become due for services provided to me include but are not limited to deductibles, co-pays, out-of-pocket expenses, and non-covered services. I am aware of the medical necessity of the services prescribed by my physician and I understand the services may be deemed reasonable and not medically necessary by my insurance. If for any reason SMS did not receive payment from my insurance, I am fully responsible for unpaid charges within 30 days of the invoice date. Charges not paid within 45 days of the invoice date may be assessed late charges, collection and attorney's fees.

Acknowledgment & Review of Patient's Bill of Rights, HIPAA Practices, & Supplier Standards: I have read, reviewed, and asked for clarification and/or copies of the handouts named above.

_____

Patient Signature (If unable to sign, a representative may sign, please print name and relationship next to the signature.)

_____ _____

Date Signature of Witness

Specialized Medical Solutions℠

Name Last:_____ First:_____ DOB: _____

Authorization for Use/ Disclosure of Information: I voluntarily authorize and direct my healthcare Provider to disclose my health information during the term of this authorization to the recipient named below.

Recipient: Specialized Medical Solutions (SMS), 7254 Blanco Rd., Suite 208, San Antonio, TX 78216.

Purpose: I understand the purpose of this authorization is for insurance to determine medical necessity.

Information to be Disclosed: This authorization permits the above provider to disclose medical records or health information pertaining to the diagnosis for which services are provided by SMS.

Term: This authorization will remain in effect until the provider fulfills the request.

Re-Disclosure: I understand once my healthcare provider disposes my health information to the recipient named above my healthcare provider cannot guarantee the recipient will not re-disclose my health information to a third-party. The third-party may not be required to abide by this authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to Sign/Right to Revoke: I understand I may refuse to sign or may revoke (at any time) this authorization for any reason and my refusal or revocation will not affect my continuation or quality of treatment by my healthcare provider.

Revocation: I understand authorization will remain in effect until the term of this authorization expires or I provide a written notice of revocation to my healthcare provider's office. The revocation will be effective immediately upon my healthcare provider's receipt of my written notice, except the revocation will not have any effect on any action taken by my healthcare provider in reliance on this authorization before I submitted my written notice of revocation.

_____

Patient Signature (If unable to sign, a representative may sign, please print name and relationship next to the signature.)

_____ _____

Date Signature of Witness

Name: _____ **DOB:** _____

Medical Questionnaire

General:

Do you live in an assisted living facility? _____ Name: _____
Are you receiving home health services? _____ Name/Number: _____
Are you receiving PT/OT Services? _____ Name/Number: _____
Name and number of referring physician to PT/OT, or home health: _____
What is your pain level today at the affected area (from 1-10, 1=mild & 10=excruciating)? _____
Have you worn compression garments? _____ Type/Brand: _____
Do you have a caretaker or family member to assist with compression garments? _____
Please list allergies to any materials you may have: _____
Functional limitations that might prevent you from wearing compression garments:
_____

Check next to all that apply:

Cancer	Pulmonary Embolism	Renal Dysfunction
Radiation	Acute DVT (Blood Clot)	Circulation Problems
Chemotherapy	Phlebitis	Diabetes
Fibromyalgia	Congestive Heart Failure	Stroke

Wound Care:

Do you have, or had in the past 6 mos., an open wound? _____ Location: _____
Did you receive wound care treatment? _____ Where? _____

Venous Insufficiency:

Do you have swelling? _____ Where? _____ Cause? _____
How long has it been present? _____ What measures are taking to control it? _____

Lymphedema:

Have you been diagnosed with lymphedema? _____ Have you been treated for lymphedema? _____
Name and number of your lymphedema provider? _____
Were you bandaged? _____ Did you receive MLD Therapy? _____ Lymphedema pump? _____

Breast Cancer:

Have you had a mastectomy? _____ Lumpectomy? _____ Date of Surgery(s): _____
Reconstruction? _____ Date of Surgery(s): _____
Physician (name and number): _____

Other Pertinent Information: _____

_____
_____