



11901 West Parmer Lane, Suite 210 • Cedar Park, TX 78613
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PATIENT INFORMATION				
Last Name:	First:	Middle Initial:	DOB:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address:		City / State / Zip:		
Home Phone:	Cell Phone:	County:		
S.S. #:	Email:			
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Other	Employment: <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired	Height:	Weight:	
How did you hear about us?				

EMERGENCY CONTACT		
Name:	Relationship:	Phone:
Address:		City / State / Zip:

REFERRING PHYSICIAN		
Physician's Name:	Phone:	City / State:

INSURANCE INFORMATION (if you do not have insurance, please write in "No Insurance")		
Policy Holder Name (if different):	DOB:	S.S. #:
Address (if different):		City / State / Zip:
Patient's Relationship to Policy Holder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other (Specify):		
Primary Insurance:	Policy #:	Group #:
Secondary Insurance:	Policy #:	Group #:

Consent for Care/Service: I have been informed about the available home medical equipment options, and I am aware of the providers from which I may choose. I authorize P&H Services, Inc. (P&H) to provide home medical equipment, supplies, and services as prescribed by my physician.

Release of Information: I hereby authorize the release of my medical and patient records, inclusive of all pertinent information acquired during treatment/services, to/from P&H, the treating physician(s), payer sources, and/or other medical providers involved with services as deemed necessary. I authorize P&H to review my medical records and payer information for the purpose of providing service.

Assignment of Benefits/Financial Responsibility: I hereby authorize payment of all health insurance benefits to P&H and allow assignee to release all information necessary to secure payment. I understand that I am responsible for providing current insurance/payer information to P&H. I agree that a photocopy of this authorization shall be considered as effective and valid as the original. **I understand that I am legally responsible for all charges incurred whether or not they are paid by my health insurance, and that any unpaid balance shall be due in full IMMEDIATELY if insurance proceeds are paid directly to me.** Charges that may become due for the services provided to me include, but are not limited to: deductibles, co-payments, 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 these services may be deemed unreasonable and not medically necessary by my insurance(s)/payer source. If for any reason P&H does not receive payment from my insurance/payer source, I will be fully responsible for the unpaid charges within 30 days of the invoice date. Charges not paid within 45 days of billing date will be assessed late charges. I am liable for all charges (including collection and attorney costs).

Acknowledgement and review of the Patient Bill of Rights, HIPAA Privacy Practices, and the Supplier Standards: I have read and reviewed the Patient Bill of Rights handout, the HIPAA Privacy Practices handout, and the Supplier Standards handout. I understand that I may request a copy of any or all of the handouts mentioned above. I have asked for clarification, if needed, regarding the handouts mentioned above.

➤ **PATIENT/GUARDIAN SIGNATURE:** _____ **DATE:** _____