SOUTH COAST D.M.E.
Your Medical Equipment Specialists

Equipment Type and Serial Number:

_____

Name:_____ _____ **Date Of Birth:**_____
Address:_____ **Age:** _____
City: _____ **Gender:** _____
State: _____ **SSN:** _____
Zip: _____
Contract Phone: _____
Work Phone: _____

Primary Insurance

Financial Class: Worker's Compensation/cash/private
Insured Name; _____
(Insured) Subscriber #: _____
Insured DOB: _____
Group (plan) Name: _____
Group#: _____
Only Cash: _____ **Rental/Purchase**_____

Insurance Name: _____
Insurance Address: _____
Insurance City: _____
Insurance Sate: _____
Insurance Zip: _____
Insurance Phone: _____
Cash Amt: _____

1. I hereby authorize the staff of **South Coast DME** to administer such treatment as may be deemed necessary or advisable in the treatment and diagnosis of my condition. This authorization is given voluntarily and I herby acknowledge that no guarantees have been made to me as to the results of treatments or equipment at the office South Coast DME.

2. I hereby authorize-**South Coast DME** to release any information acquitted in the course of my treatment to any person or corporation, including but not limited to the Social Security Administration, Insurance Carriers, Worker's Compensation Carriers, Welfare Funds or Employers, PROVIDING such agent has a financial liability for any treatment at- **South Coast DME** office.

3. I hereby give my permission, when applicable, for my Insurance Company to pay- **South Coast DME** directly. I further agree to pay any balance due and payable.

4. I understand that I am responsible, prior to treatment, for inquiring with my Insurance Company as to the benefits of my policy for services provided by- **South Coast DME**

5. I understand and acknowledge that my Health Information is protected and confidential, and I have received a copy of the patient privacy policy.

_____

DATE SIGNED (Insured or Authorized)

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