# COMPRESSION CARE

## DME CERTIFICATE & RECEIPT FORM

☐ Picked Up at Facility ☐ Delivered to Patient

### PATIENT INFORMATION

| | | | |
|---|---|---|---|
| Name | | Date of Birth (MM/DD/YYYY) | |
| Address | | | |
| City | State | Zip | Phone |
| Additional Comments: | | | |

### PRODUCT INFORMATION

| Product Description | Manufacturer/Style | Size/Color | Qty | Received | Inspected |
|---|---|---|---|---|---|
| Compression Bra (L8001) | | | | | |
| Compression Sleeve (S8422/S8423/S8424) | | | | | |
| Hand Gauntlet (S8428) | | | | | |
| Hand Glove (S8427/S8425) | | | | | |
| Leg Garment (A6531/A6534/A6540) | | | | | |
| Custom Leg Garment (A4465/A6549) | | | | | |
| Compression Wrap (S8429) | | | | | |
| Compression Bandages (A6452) | | | | | |
| Other | | | | | |

**Authorization to Assign Benefits to Provider (Consent for Payment):** I hereby request payment of my carrier be made on my behalf to Some Other Company, Inc DBA Pretty in Pink Boutique for products and services that are provided to me. I authorize the holder of medical information about me to release it to Some Other Company, Inc DBA Pretty in Pink Boutique and to its agents as the information is needed to determine these benefits payable for related services. I hereby authorize payment of medical benefits billed to my insurance by Some Other Company, Inc DBA Pretty in Pink Boutique. I have listed all health insurance plans from which I may receive benefits. I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I agree to pay all copayments, coinsurance, and deductibles at the time services are rendered. I also accept responsibility for fees that exceed the payment made by my insurance if Some Other Company, Inc DBA Pretty in Pink Boutique do not participate with my insurance. I hereby authorize Some Other Company, Inc DBA Pretty in Pink Boutique to use and/or disclose my health information which specifically identities me or which can reasonably be used to identify me to carry out my treatment, payment, and healthcare operations.

**ACKNOWLEDGEMENT OF RECEIPT (Proof of Delivery)** I acknowledge that I have received the DMEPOS product(s), complete instructions on the use, care, maintenance, and full documentation for the DMEPOS Product(s) listed above. The equipment has been properly fitted to the client and/or meets the client's needs. The client, parent, the guardian of the client, and/or caregiver of the client has received training and instruction regarding the equipment's proper use and maintenance.

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|---|---|
| ▶ **Patient Signature:** | **Date:** |
| Patient Representative (If Patient Unable to Sign) | Relationship |

**Rendering Provider:** **Some Other Company, Inc DBA Pretty in Pink Boutique**

**Location:** **3343 Aspen Grove Dr Ste 220, Franklin, TN 37067-2916**

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|---|---|
| ▶ **Pretty In Pink Boutique Representative:** | **Date:** |