REFERRING PROVIDER _____

ACCOUNT EXECUTIVE _____

WEST COAST MEDICAL

PATIENT INTAKE FORM AND ASSIGNMENT OF BENEFITS

PATIENT DEMOGRAPHICS

Date of Birth / /

Patient Name

Patient Address

City ST Zip

Phone Number Email Address

Social Security No Circle one **Male** **Female**

Employer Name Employer Phone

Insurance Info ☐ Group ☐ P.I. ☐ Work Comp

Primary Insurance Co Insurance Phone No

Policy/Claim No Group No

Claims Mailing Address

City ST Zip

Attorney Name Phone:

Fax:

Attorney Mailing Address D.O.I / /

PATIENT AUTHORIZATION

I authorize payment of medical benefits to West Coast Medical, Inc. I understand that this equipment is to be used only for my diagnosed condition and is issued under a doctor's prescription. I have been fully instructed on the use of this equipment and am aware of the warnings and precautions. I absolve West Coast Medical, Inc. of any responsibility in the event of an accident or injury caused directly or indirectly in the use of rented or purchased equipment. I assign any & all rights & benefits of my insurance policy and any causes of action in order to collect from my insurance company to West Coast Medical, Inc. I further acknowledge my insurance carrier may send, directly to me, monies meant for reimbursement to West Coast Medical, Inc. for services provided. In the event I receive this reimbursement, I agree to forward it to West Coast Medical, Inc. within five (5) business days. I am aware that West Coast Medical, Inc's policy is to pursue collection of any reimbursement made for their service(s) which is not forwarded for this payment by the insured.

I authorize West Coast Medical, Inc. to provide supplies needed based on my prescription from my physician. I understand that I will be receiving DME delivered to me directly by West Coast Medical, Inc., and I agree to receive these shipments as prescribed by my doctor. Should I wish to terminate my prescription, I understand that it is my responsibility to notify West Coast Medical, Inc. I understand that, due to health regulations, supplies are non-returnable.

I hereby authorize and direct you, my attorney and/or insurance carrier, to pay directly to West Coast Medical, Inc., such sums that may be due for the medical services rendered. I hereby, further, give a lien on my case to West Coast Medical, Inc. against any and all proceeds of any settlement, judgement or verdict that may be paid to you, my attorney or me. I do hereby appoint West Coast Medical, Inc.to accept on my behalf all checks, drafts, or bills of exchange.

I authorize the release of medical records & information needed to determine and/or substantiate medical necessity. I also give authorization for West Coast Medical, Inc. to appeal any denials of payment on my behalf with my insurance carrier. I permit a copy of this authorization to be used in place of the original.

By my signature below, I acknowledge that I have read, understand & agree with the statements contained above & also acknowledge the receipt of the prescribed equipment.

Patient Signature: _____ Date:_____

******IF PATIENT IS A MINOR******

Guardian Signature: _____ *Printed Name:* _____ *Relationship:* _____

OFFICE USE ONLY

P.O. BOX 365 ● NEWBURY PARK, CA 91319 ● PHONE 888.578.4826 ● FAX 888.318.4826