TRANSCEND MEDICAL

Going Beyond The Limits

800-403-3740

Delivery Date: ______________

Pick-Up Date: ______________

Reason for Pick-Up: __________

Last Name ______________________ First Name ________________ MI __________ DOB ___________

Height _______ Weight ________ Sex: M or F Phone _________________ Cell Phone ____________________

Street Address _______________________ City ______________ St _____ Zip __________ DX_________________

Email address: ______________________________ Other Contact ______________________________________

Name on Primary Insurance ______________________________ Insurance Phone # ________________________

Subscriber's Name ____________________________________ DOB _________ Phone ___________________

ID # __________________________ Group # ____________ Relation: Self___ Spouse ____ Child ____

Name of Secondary Insurance _____________________________ Insurance Phone # _______________________

Subscriber's Name ____________________________________ DOB _________ Phone ___________________

ID # __________________________ Group # ____________ Relation: Self___ Spouse ____ Child ____

QTY	HCPS CODE	Product Description	Serial #	Manf	P or R	Amount Paid

Appropriate for Home: Yes ___ NO ___ Understands operation of equipment _____ Has Caregiver and instructed ______

Assignment/Consent

I hereby authorize my insurance carrier(s) to accept assignment and pay directly to Porch Home Medical for services rendered on my behalf. I hereby acknowledge that I am responsible for all charges for services rendered and agree to pay such charges or any portion remaining after my insurance carrier(s) pays. I have been instructed on the proper use of the above-mentioned medical equipment. I have received delivery of the above listed equipment/supplies. I certify that the equipment listed above has been picked up and returned if so, noted as a pick-up slip. Transcend Medical has provided me with the appropriate information (verbal and written) related to the set-up features, routines use, troubleshooting, cleaning, and maintenance of all equipment/supplies provided. The above listed information has been given to provide information necessary to bill your insurance provider for services provided. I certify that the information is correct. I authorize any holder of medical or other information about me to release to the Social Security Administrator and Health Care Financing Administrator or their intermediaries or to the billing agent of Transcend Medical, any information for this or any related health claim. I agree to permit a copy of this authorization to be used in place of an original. I authorize Transcend Medical to release records for the purpose of obtaining payment or medical treatment. Such records may be released to any agency or individual authorized to receive such information. I understand I have the right to refuse to release Transcend Medical records and that signing this consent constitutes a waiver of the right for a period of two years. I request that payment of authorized benefits be made to Transcend Medical. This authorizes Physicians, hospitals, and all medical attendants to furnish full and complete medical reports and information requested by the undersigned to Transcend Medical.

I HAVE READ AND UNDERSTAND THE PROVISIONS OF THIS FORM. I UNDERSTAND THAT MY SIGNATURE BELOW SHALL BE EVIDENCE OF MY AGREEMENT TO THE PROVISIONS OF THIS FORM. I HAVE READ AND UNDERSTAND THE COMPANY'S RETURN POLICY.

______________________________ ________ ______________________________

CUSTOMER SIGNATURE DATE TRANSCEND MEDICAL REPRESENTATIVE

______________________________ ______________________________

BY, IF OTHER THAN CUSTOMER PRINTED NAME & RELATIONSHIP TO PATIENT