PATIENT REGISTRATION FORM

Rep Name:

PATIENT INFORMATION

Last Name:	First:	Middle:	Marital Status: Single ☐ Married ☐ Other ☐
Date of Birth:	Sex: ☐ M ☐ F	Home Phone:	Social Security #:
		Cell / Work Phone :	
Street address:		City:	State: ZIP Code:
Employer:	Current Email Address:		

INSURANCE INFORMATION

Primary Insurance: _____ Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other

Please Indicate →	☐ Group	☐ Auto Accident	☐ Worker's Comp	☐ Other
ID#:	Group#:	**Auto or Work Comp Only**	Adjuster's Name:	State in which accident occurred:
			Phone Number:	

Complete below if patient is NOT the policy holder

Policy Holder's Name:				Date of Birth:	
Patient's Relationship to Insured:	☐ Self	☐ Spouse	☐ Child	☐ Other	
Policy Holder's Address:			Policy Holder's Phone:		

Name of **secondary insurance** (if applicable):	Subscriber's name:	ID/Policy#:	Group#:

Patient's relationship to insured:	☐ Self	☐ Spouse	☐ Child	☐ Other

I understand that Advantaged Medical Solutions functions only as a supplier. 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 in the use of this equipment and I am aware of the warnings and precautions. I absolve Advantaged Medical Solutions of any responsibility in the event of any accident or injury caused directly or indirectly in the use of equipment and supplies.

I authorize Advantaged Medical Solutions to provide supplies needed based on my prescription from the physician. Should my supplies become over/ under-stocked, I understand that it is my responsibility to notify Advantaged Medical Solutions

I understand that due to health regulations, supplies are non-returnable due to our commitment to offering sterile and new equipment to you.

I hereby authorize and direct you, my attorney and or insurance company to pay directly to Advantaged Medical Solutions, such sums that may be due for the medical services rendered. In the event that my insurance company has a preferred provider that is considered in-network, I instruct my insurance company to apply my out of network benefits. I hereby further give a lien on my case to Advantaged Medical Solutions against any and all proceeds of any settlement, judgment or verdict that may be paid to you, my attorney or me.

I authorize the release of medical records and information needed to determine benefits and or substantiate medical necessity. I also give authorization for Advantaged Medical Solutions 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 am acknowledging that I have read, understand and agree with the statements contained above and also confirm the receipt of the prescribed equipment and supplies.

Patient/Parent/Guardian Signature: _____ Date: _____

Office Use Only

Equipment: ☐TENS ☐EMS ☐Microcurrent ☐INF ☐JStim Hand/Knee ☐Mesh Garment ☐Cervical Traction ☐Cervical PP ☐Lumbar PP ☐Lumbar Support	Serial Number:

Diagnosis Codes: _____ _____ _____

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