Innovative Interventions, LLC

"Your Trusted Partner in Patient Care"

www.innovativeinterventionsllc.com ***Fax: 772-673-6198***

PATIENT DEMOGRAPHICS

PATIENT NAME: _____ DOB: _____

PATIENT ADDRESS: _____
STREET CITY STATE ZIP

PHONE NUMBER: _____ CELL PHONE NUMBER: _____ SS#: _____

HAVE YOU RCVD AN ITEM LIKE THIS BEFORE? Y N IF YES, WHEN? _____ WHAT HAPPENED TO IT? _____

PATIENT ACKNOWLEDGMENT / ASSIGNMENT OF BENEFITS

By signing below, you are acknowledging the following:

- ✓ I have been instructed on the proper use of the below supplies. Manufacturer warranty applies.
- ✓ I authorize payment of medical benefits to the biller for the services furnished. I further authorize the release of any medical information required to process insurance claims on my behalf. I permit a copy of this authorization to be used as the original.
- ✓ I understand that all costs not paid by my insurance company are my responsibility.

PATIENT SIGNATURE: X _____ DATE: _____

RESPONSIBLE PARTY: X _____ RELATIONSHIP: _____

REASON PATIENT CANNOT SIGN: _____

PRESCRIBING PHYSICIAN'S ORDER

- ☐ L0639 LS0
- ☐ L0650/ L0637 LSO
- ☐ TLSO Brace
- ☐ Aspen Vista MP Collar L0180
- ☐ Hinged Knee Brace L1832, Knee sleeve
- ☐ OA Knee Brace
- ☐ Wrist and Thumb L3809
- ☐ Wrist Extension Splint L3908
- ☐ Premium Air Walker Boot L4360
- ☐ Ankle Brace
- ☐ Other _____

☐ Left ☐ Right

☐ XS ☐ S ☐ M ☐ L ☐ XL ☐ XXL

- ☐ M47.817 Lumbosacral Spondylosis
- ☐ M54.5 Lumbago
- ☐ M43.8X9 or M53.9** Spinal Disorder
- ☐ M51.36 or M51.37** Degenerative Disc Disease
- ☐ M48.00 Spinal Stenosis
- ☐ M79.9 Radiculopathy
- ☐ S33.5XXA Strain and Sprain
- ☐ M62.81 Muscle Weakness
- ☐ M48.02 Cervical Stenosis
- ☐ M17.10 Osteoarthritis
- ☐ S83.429A Strain/Sprain Knee
- ☐ Other _____

**could be either

Place Product Sticker Here

Please check only those that pertain. Item was ordered to:

☐ Reduce pain by restricting mobility of the trunk
☐ Facilitate healing following an injury to the spine or related soft tissues
☐ Facilitate healing following a surgical procedure on the spine or related soft tissue
☐ Otherwise support weak spinal muscles and/or a deformed spine

****** Please attach office notes ******

PHYSICIAN'S NAME: _____ NPI: _____

PHYSICIAN'S ADDRESS: _____

PHYSICIAN'S HANDWRITTEN SIGNATURE: X _____ DATE: _____

Rep Initials

********* PLEASE ATTACH PATIENT DEMOGRAPHICS/INSURANCE INFO**********

** IF THIS FORM IS NOT COMPLETE, THE PATIENT WILL BE BILLED** REV. 7.1.2022

INNOVATIVE INTERVENTIONS, LLC CANNOT ACCEPT RETURNS DUE TO THE PERSONAL NATURE OF THIS PRODUCT