



113 Production Dr., Ste. 2 • Slidell, LA 70460
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www.LifecareMedical.com

UPDATED PATIENT PAPERWORK

PATIENT NAME: _____

DOB: _____ HOME #: _____ CELL #: _____

EMAIL ADDRESS: _____

CANNOT SHIP TO PO BOXES. PLEASE MAKE SURE THIS IS A PHYSICAL ADDRESS

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

MEDICAL INFORMATION

PRIMARY INSURANCE: _____

MEMBER ID: _____ GROUP #: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE #: _____

SECONDARY INSURANCE: _____

MEMBER ID: _____ GROUP #: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE #: _____

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RELEASE OF INFORMATION POLICY

I authorize the release of any medical information necessary to process any insurance claims for any items provided to me by Lifecare Technology, Inc. I authorize payment of any private insurance company, government of JCAHO benefits to Lifecare Technology, Inc. I understand I am responsible for any charges not paid by my insurance company(s).

Furthermore, I authorized the about named authorized representative, to act in my behalf as my representative in all matters of business with Lifecare Technology, Inc. Your supplies will be supplied to you from Lifecare Technology, Inc. for questions, service to order additional supplies please call 985.649.3019. Our office hours are Monday - Friday 9:00am - 4:00pm Cash, Check, Visa or MasterCard is accepted for non-covered items, and/or deductible and co-payments. I understand that i am responsible for payment if i fail to update Lifecare Technology, Inc. of any changes in healthcare, insurance or living arrangements.

CONSENT TO BILL: MEDICARE/MEDICAID/PRIVATE INSURANCE

I request that a payment of authorized (Medicare/Medicaid/Private) benefits be made on my (beneficiary) behalf of Lifecare Technology, Inc. for any services furnished. Any holder of Medical or other information about me (beneficiary) is authorized to release to the center for Medicare and Medicaid services and / or Private Insurance, and its agents, any information needed to determine these benefits for release services.

I understand that Lifecare Technology, Inc. reserves the right to review all agreements on an individual basis to determine the continued acceptance of assignment for Medicare and / or any other medical insurance companies. In the event of medical necessity no longer exists or my payer no longer deems any supplies to be covered i understand that i will be responsible for all payments to Lifecare Technology, Inc.

I have recieved and understand my Patient / Client of Bill of Rights, Medicare DMEPOS supplies Standards, and Notice of Privacy. In addition, I agree that Lifecare Technology, Inc. may contact me in the future via telephone or other means of communication regarding medical supplies.

ASSIGNMENT / SIGNATURE ON FILE AGREEMENT

I request that payment of authorized medical benefits be made to Lifecare Technology, Inc. for any covered services furnished to me. In cases where Lifecare Technology, Inc. will accept the charge determination as the full charge for the covered services. I am always responsible for the deductible, co-insurance, and unassigned uncovered services. I agree to pay Lifecare Technology, Inc. any payment made directly to me by insurance for services provided by Lifecare Technology, Inc on an assigned basis. I understand that Lifecare Technology, Inc. does not accept returned merchandise if worn, used for sanitary/hygienic purposes, or if it is disposable. It is my responsibility to inform Lifecare Technology, Inc. if I relocate, no longer need supplies, or am admitted to a Hospital or Nursing Facility.

PRINT PATIENT NAME: _____ **DATE:** _____

PATIENT SIGNATURE: _____ **DATE:** _____

REPRESENTATIVE'S NAME: _____ **DATE:** _____

REPRESENTATIVE'S SIGNATURE: _____ **DATE:** _____

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