11901 West Parmer Lane, Suite 210 • Cedar Park, TX 78613
5920 W. William Cannon Bldg. 6 Suite 225 Austin, TX 78749
(512) 986-6291 • (512) 986-6330 Fax • www.phservnet.com

PATIENT INFORMATION				
Last Name:	First:	Middle Initial:	DOB:	☐ Male ☐ Female
Address:		City / State / Zip:		
Home Phone:	Cell Phone:		Employer & Work Phone:	
Marital Status: ☐ Married ☐ Single ☐ Other	Email			

EMERGENCY CONTACT		
Name:	Relationship:	Phone:

REFERRING PHYSICIAN		
Physician's Name:	Phone:	City / State:

HOW DID YOU HEAR ABOUT US?		
Therapist: Pt or OT	Doctor:	Other:

INSURANCE INFORMATION (if you do not have insurance, please write in "No Insurance")			
Policy Holder Name (if different):	DOB:	Patient's Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other (Specify)	
Address (if different):	City / State / Zip:		
Primary Insurance:	Policy #:	Group #:	
Secondary Insurance:	Policy #:	Group #:	

____ **Consent for Care/Service:** I have been informed about the available home medical equipment options, and I am aware of the providers from which I may choose. I authorize P&H Services, LLC. (P&H) to provide home medical equipment, supplies, and services as prescribed by my physician.

____ **Release of Information/Purpose:** I hereby authorize the release of my medical and patient records, inclusive of all pertinent information acquired during treatment/services, to/from P&H, the treating physician(s), payer sources, and/or other medical providers involved with services as deemed necessary. I authorize P&H to review and maintain my medical records and payer information for the purpose of providing service.

____ **Assignment of Benefits/Financial Responsibility:** I hereby authorize payment of all health insurance benefits to P&H and allow assignee to release all information necessary to secure payment. I understand that I am responsible for providing current insurance/payer information to P&H. I agree that a photocopy of this authorization shall be considered as effective and valid as the original. **I understand that I am legally responsible for all charges incurred whether or not they are paid by my health insurance, and that any unpaid balance shall be due in full IMMEDIATELY if insurance proceeds are paid directly to me.** Charges that may become due for the services provided to me include, but are not limited to: deductibles, co-payments, out-of-pocket expenses, and non-covered services. I am aware of the medical necessity of the services prescribed by my physician, and I understand these services may be deemed unreasonable and not medically necessary by my insurance(s)/payer source. If for any reason P&H does not receive payment from my insurance/payer source, I will be fully responsible for the unpaid charges within 30 days of the invoice date. Charges not paid within 45 days of billing date will be assessed late charges. I am liable for all charges (including collection and attorney costs).

____ **Refusal to sign/right to revoke**: I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by my health care provider.

____ **Acknowledgement and review of the Patient Bill of Rights, HIPAA Privacy Practices, and the Supplier Standards:** I have read and reviewed the Patient Bill of Rights handout, the HIPAA Privacy Practices handout, and the Supplier Standards handout. I understand that I may request a copy of any or all of the handouts mentioned above. I have asked for clarification, if needed, regarding the handouts mentioned above.

____ **By providing my email above:** I authorize P & H Services, LLC to email me regarding my order or other services. I understand that emails containing PHI will be encrypted. Encrypted email will require that I click on a provided link and create a password in order to review the secure email.

➢ **PATIENT/GUARDIAN SIGNATURE**: _____ **DATE**:_____