Patient Information Form

PO Box 261421 Tampa, FL 33685
855-ESTiM-10 888-724-1478 fax

Patient Name: ______________________________	HM#: ______________________________
Address: ______________________________	SS#: ________-________-________
______________________________	DOB: ________/________/________
______________________________	Sex: (M / F)
Insurance Name: ______________________	Insurance Phone: ______________________
Insurance Address: ______________________	Policy/Claim#: ______________________
______________________________	Date of Accident: ________/________/________
Attorney: ______________________________	______________________________

PATIENT'S AUTHORIZATION / RELEASE / LIEN

I am under the care of Dr. ________________________________ It has been determined that _________________ is an effective modality for my diagnosed condition.

ESTiM is the 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 instructed on the use of this equipment and am aware of the warnings and precautions. I absolve **ESTiM** of any responsibility as a result of any accident directly or indirectly while using the equipment.

I authorize **ESTiM** to provide the supplies needed monthly / quarterly. Should my supplies become over stocked, I understand that it is my responsibility to contact **ESTiM**.

I agree to provide **ESTiM** with any requested information (primary, secondary insurance / attorney). In the event I receive money due to **ESTiM** either by insurance or through settlement. I agree to forward the money to **ESTiM**. I hereby instruct my attorney to provide **ESTiM** with either a letter of protection; and for my attorney / insurance company to pay accrued charges directly to **ESTiM** at the time of claim or settlement. I will be responsible for returning items not paid. I accept and understand that this agreement is irrevocable.

I, ____________________________ do hereby authorize and direct you, __________________________to pay any and all sums directly to the said medical facility, **ESTiM**, for any such medical services rendered by reason of this diagnosed condition and/or accident. I authorize the release of medical records and information needed to determine benefits and/or substantiate medical necessity. I permit a copy of this authorization to be used in place of the original. I have read and understand the above. By my signature below, I am acknowledging receipt of the above-described equipment.

Patient Signature: ____ Date: ____________________