

PRIVATE PAY ORDER FORM

****Please attach face sheet w/ patient demographics****

PATIENT INFORMATION

Patient Name: _____ DOB: ____/____/____ Gender: Male Female
Language Pref.: English Spanish Other: _____ Does this patient have insurance? Yes No

PRODUCT SELECTION

	Qty	Cost
Total:		

REFERRAL INFORMATION

Practice Name: _____ Fax: _____
Office Address: _____ Email: _____
Phone: _____ Preferred Method of Contact? Phone Fax Email

Physician Name: _____ NPI#: _____ Phone: (_____)_____-_____- Ext. _____
Physician Signature: _____ Date: ____/____/____

I certify that the above products are medically necessary and that the information provided is accurate to the best of my knowledge. By signing below, I acknowledge that I have obtained the patient's authorization to release the above information and other medical information that may be disclosed. I certify that my decision to prescribe this recommended product was solely based on my determination of medical necessity set forth herein. This document may serve as a confirmation of a verbal order and is also recorded in the patient's record.

Patient Signature: _____ Date: ____/____/____