

Compression Order Consent Form

Patient Name: _____ DOB: _____

Garment Description: R L B N/A

Order Consent/Assignment of Benefits:

I authorize D&J Compression to fabricate, or order the device prescribed by my physician. I agree to accept the device when notified by D&J Compression that it is completed. I agree that my insurance carrier will be billed for this device and that I may be responsible for any charges not covered by my carrier.

Consent for Release of Medical Information:

In order to verify your insurance benefit coverage for compression garments, it is necessary for us to provide our vendors with your personal information. This information will include your name, address, phone numbers, and insurance coverage. It is also necessary for us to provide portions of your insurer in order to facilitate payment. I have received information regarding privacy practices and HIPAA regulations.

Warranty Information:

D&J Compression guarantees that the compression garments being provided to you will be made to your measurements and properly fitted to correspond to your anatomical condition at the time of your visit. When necessary, your garments will be returned for replacement at no charge to you or your insurance company for a period of 15 days from the date of delivery to our office.

For additional information please visit our website at www.dandjcompression.com.

By signing my name below, I certify that I have read and consent to all of the above information.

Patient Signature: _____ Date: _____

Representative/Guardian: _____ Date: _____

FOR OFFICE USE ONLY

DX Code: _____ Practitioner: _____

Delivery Address: _____

Delivery Signature/Tracking Number: _____ Date: _____

FOR NATIONAL ORDERS ONLY

**Please email or fax this form to: order@dandjcompression.com / 866.225.0816
or call 844.365.7237 for more information.**