National Diagnostic Services, LLC.
110 W. Reynolds St, Suite 105
Plant City, Fl 33563
Phone: 877-582-0202 Fax: 866-636-0202

Patient Verbal Order Information

Patient Name: _____ DOB: _____

Address: _____ City / St / Zip: _____

Phone: _____ SSN: _____ Gender: M: □ F: □

DME Provider Information: Name: _____ Phone: _____

City: _____ State: _____ Fax: _____

Insurance Information

Primary Insurance:

☐ Medicare Medicare Number: _____

☐ Medicaid Medicaid Number: _____ State: _____

☐ Medicare Policy Number: _____ Group #: _____

Insurance Name: _____ Phone: _____

Address: _____ City / State / Zip: _____

Insured Person: _____ Self: ☐ Spouse: ☐ Child: ☐ Other: ☐

Assignment of Benefits / Statement of Authenticity Required

I, the undersigned, hereby authorize payment be made on my behalf to the organization list at the top of this page for authorized insurance benefits, including Medicare, If I am a Medicare beneficiary. I understand that I am financially responsible to the organization for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claim or any part of them are denied payment. I understand by signing below, that I am accepting financial responsibility as explained above for all payment for products and services received.

I, the undersigned, also certify that I am the recipient of the oximetry testing unit and that the test was actually performed on me at the date and times specified below. I also certify that I have not, nor has the the courier of this test tampered with or altered this test in any way and that it will be downloaded in its orignial form.

Test Done on:	Test Started:	Test Ended:
□ Room Air □ Oxygen □ Cpap/ Bipap	Date: _____ Time:	Date: _____ Time: _____

Patient Signature: _____ Date: _____

Medical Release

I, the undersigned, authorized the organization at the top of the page to use and disclose my health information for the purpose of treatment obtaining payment, or supporting the health care operations of my ordering physician. I also authorize the organization at the top of this page to use facsimile with confidential disclosure of my results to any ordering physician and the DME provider listed above. (Note: You may call us using the number above if you would like to review our Notice of Privacy Practices before signing below.)

Patient Signature: _____ Date: _____