Pro Med, Inc.
7125 Marvin D. Love Frwy. #360
Dallas TX 75237

PATIENT AGREEMENT AND RX

For Durable Medical Equipment

Fax 214-242-8079
PHONE 972-773-9308
Email: dme@promedortho.com

Patient Information

Name:	DOB:	Ins./Atty	DOI
Phone:	Male / Female		DIAG CODES
Address:		Phone:	
Prescribing Physician:		Fax:	
Physician Phone #:	Fax #:	NPI #:	

Rx: Doctor, please indicate all services you would like Pro Med Inc. to provide to your patient: Please include any special instructions necessary to ensure accurate and specific treatment.

INJURY CARE

Cervical	Lumbar	Knee	Shoulder	Hand/Wrist	Foot/Ankle Injury
Cervical Roll Cervical Orthosis ☐ Hot/Cold Therapy EMS/NMES With Supply	Back Brace ☐ Hot/Cold Therapy EMS/NMES With Supply	Knee Brace ☐ Hot/Cold Therapy EMS/NMES With Supply	Shoulder Immobilizer Shoulder Pulley ☐ Hot/Cold Therapy EMS/NMES With Supply	Wrist Brace ☐ Hot/Cold Therapy EMS/NMES With Supply	Pneumatic Walker ☐ Hot/Cold Therapy EMS/NMES With Supply

AMBULATORY

□ Single Point Cane/4 Point
□ Crutches
□ Wheelchair
□ Walker/Rollator Walker/Knee Walker

EXTREMITIES

□ Wrist Cock Up □ Thumb Spica
□ Breg Shortrunner w/ Hinges
□ Functional ACL Brace
□ OA Knee Brace □ L1845
□ Soft OA Brace Undersleeve □ L2397
□ Knee Immobilizer
□ Pneumatic Walking Boot
□ Fracture Boot
□ Ankle Brace
□ Ankle Stir-Up
□ Shoulder Abduction Sling
□ Shoulder Immobilizer
□ Plantar Fasciitis Night Splint

Home Therapy

□ Moist/Dry Heat Pad □ Shoulder Therapy Kit
□ Hand Therapy □ Active Cold Therapy Systems
□ Home Therapy Equipment _____

CERVICAL AND LUMBAR

□ Cervical Collar-Soft/Cervical Collar Semi Rigid-Aspen
□ Lumbar Back Brace (LSO)_____
□ TLSO
□ Lumbar Pillow/Cervical Pillow
□ Cervical Traction/Over Door
□ Apex Cervical Orthosis

STIM/EMS

□ NMES/EMS/TENS Unit (Serial #) _____
□ STIM Garment
□ Conductive Spray 8 OZ 12OZ
□ Batteries 4 6 8 10
□ Electrodes 4PKS PER MTH 1MTH 3MTHS 6MTHS 12MTHS 99MTHS

Pain Management/Anti Inflammatory

□ sam® Sport □ sam® Sport Patches: 2 Months

Miscellaneous/Post Op

□ DVT Compression System
□ Bone Growth Stim □ Spinal □ Long Bone
□ Post Op T-Scope Knee Brace □ Post Op T-Scope Elbow Brace
□ CPM: Shoulder / Knee / Hand

PLACE LABEL HERE

□ MISC_____
Item Purchase/Rental Serial/Item #

Physician Signature:_____ **Date:**_____

I have prescribed the above durable medical equipment for treatment of the referenced patient. It is both reasonable and medically necessary effectuate a maximum and expedient recovery. CHECK ALL THAT APPLY. It is prescribed to

□ Reduce Pain
□ Reduce Muscle Spasm
□ Post- Operative/Post Procedural Pain Control and Edema
□ Reduce Reliance on Narcotics/Analgesics
□ Reduce Edema/Swelling
□ Increase Range of Motion (ROM)
□ Post-Operative/Surgical Procedure
□ Other (specify below):
_____

To be signed and completed by patient upon receipt of product(s):

Dear Patient: PLEASE READ THIS STATEMENT AND SIGN BELOW

Pro Med Inc. is not financially affiliated with the medical group or physician. Your physician must prescribe all services and/or products provided by Pro Med Inc. I here-by authorize Pro Med Inc. to furnish this service/product and to provide my insurance company with any information requested for payment. I also instruct my insurance company to pay Pro Med Inc. directly for these service/products. I understand that all costs for service/products not paid for by my insurance company for any reason will become my personal financial responsibility. Assignment of benefits does not guarantee that my insurance company will pay for these service/products. I have received the above referenced product/services from Pro Med Inc., and have been instructed in the care and use of the product. I understand that all medical devices are not returnable for any reason other than material defect. MEDICARE AND OTHER INSURANCE COMPANIES will only pay for services/products that they determine to be reasonable and necessary under section 1862(a)(1) of the Medicare regulations. It Medicare or other insurance company determines that the product/service, although otherwise a covered product/service, is not reasonable or necessary under Medicare or other Insurance company standards. Medicare or other insurance company may deny payment for these service/products. Pro Med Inc. cannot be certain that Medicare or other Insurance company will view your doctor's request for the above listed product/service to be reasonable or necessary or that your doctor's supporting documentation will be accepted by Medicare or other insurance company. I have been advised of my privacy rights pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations.

□ Check here if you would like to receive electrodes supplies for 24 month

Patient/Legal Guardian Signature:_____ **Date:**_____