# EMBRACE DIABETESE FOOTWEAR SOLUTIONS

**982 N. COOPER ST.**
**ARLINGTON, TX 76011**
**PH: 817-460-3504/855-460-3504 FX: 817-460-3502**
**EMAIL: EMBRACEDFS@GMAIL.COM**

## PATIENT AUTHORIZATION FORM

In order for *EMBRACE DIABETES FOOTWEAR SOLUTIONS.* (equipment & supplies) to provide you with your needed services and to receive reimbursement from you insurer(s), please complete, sign, and date this form and return it to us for immediate processing.

**ITEMS NEEDED:**
**1._____2._____3._____**

**PATIENT INFORMATION:**

PATIENT NAME: _____ ACCT NO**. (OFFICE USE ONLY)**_____
ADDRESS: _____
CITY: _____ST: _____ ZIP: _____
DATE OF BIRTH: _____ SOCIAL SECURITY #: _____
HOME PHONE #: _____ OTHER: _____
SEX: M___ F___ HT: _____ WT: _____
**REFERRED BY:** _____
**IF ANY:**

**PRIMARY INSURANCE NAME: _____ POLICY #:_____**
PHONE #: _____ FAX: _____
**SECONDARY INS. NAME: _____ POLICY #: _____**
PHONE #: _____ FAX: _____

**NEXT OF KIN:**
NAME: _____ RELATIONSHIP: _____
ADDRESS: _____CITY: _____ST: ___ ZIP: _____
PHONE #: _____ FAX #: _____

**PHYSICIAN INFORMATION:**
PHYSICIAN NAME: _____ NPI #: _____
ADDRESS: _____ CITY: _____ ST: __ ZIP: _____
PHONE #: _____ FAX#: _____

I _____ AUTHORIZE THE RELEASE OF ANY NECESSARY MEDICAL INFORMATION AND PAYMENT OF MEDICAL BENEFITS FOR SERVICES AND SUPPLIES THAT I RECEIVE. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL DEDUCTIBLE AND APPLICABLE CO-INSURANCE AMOUNTS THAT ARE NOT COVERED BY OR ARE DENIED BY MY INSURANCE. I WILL NOTIFY *EMBRACE DIABETES FOOTWEAR SOLUTIONS.* PROMPTLY OF ANY CHANGES THAT WILL AFFECT INSURANCE REIMBURSEMENT.

****I AM NO RECEIVING SAME SUPPLIES FROM ANOTHER DME SUPPLY COMPANY. INTIALS _____**

_____ _____
**PATIENT SIGNATURE** **DATE**