EScience Medical

QualCare Therapy Center

7215 Wyoming Springs, Ste. 600, Round Rock TX 78681
800 Brazos Street, Ste. 1400, Austin TX 78701
TEL: 512.255.2727 FAX: 512.255.6277

DME Medical Equipment Questionnaire

DIAGNOSIS

PRIMARY

SECONDARY

ALLERGIES:
____NKA ____OTHER (SEE COMMENTS)

CHRONIC CARE MANAGEMENT: COMORBIDITY (CHECK THAT APPLIES)

___HYPERTENSION ___BMI > 35 (OBESITY) ___CONGESTIVE HEART FAILURE ____ TYPE 2 DIABETES

___PACEMAKER ___ATRIAL FIBRILLATION ___CORONARY ARTERY DISEASE

FUNCTIONAL LIMITATIONS:

_____ NO LIMITATIONS

_____ ANY LIMITATIONS THAT MIGHT EFFECT ABILITY TO OPERATE/MAINTAIN PAP EQUIPMENT

SPECIFY:

ACTIVITIES PERMITTED:

___ NO RESTRICTIONS
___ AMBULATORY WITH AID
___ BED BOUND

TEACHING ASSESSMENT:

PATIENT/CAREGIVER IS ABLE TO UNDERSTAND INSTRUCTIONS ON EQUIPMENT
___YES ___NO

SUPPORT SYSTEM:

___ PATIENT IS INDEPENDENT

___ PATIENT LIVES ALONE W/OUTSIDE PERSON AVAILABLE FOR SUPPORT

___ PATIENT LIVES WITH FAMILY / CAREGIVER

___ PATIENT LIVES ALONG AND NEED SUPPORT

HOME ENVIRONMENT:

___ YES ___ NO PRESENCE OF SMOKE ALARM (PATIENT NOTIFIED)

___ YES ___ NO ADEQUATE SPACE FOR EQUIPMENT

___ YES ___ NO PATIENT SMOKE

___ YES ___ NO PATIENT ADVISED OF ELECTRICAL REQUIREMENTS

___ YES ___ NO ELECTRICAL ADAPTER PROVIDED

___ YES ___ NO CLEAN ENVIRONMENT

OTHER FACTORS EFFECTING SUITABILITY: (SPECIFY)

PRESCRIPTION:

PROBLEM / NEED:

SEE DIAGNOSIS AND PRESCRIPTION ___ OTHER: (SPECIFY)

GOAL:

____ PATIENT / CAREGIVER WILL BE KNOWLEDGEABLE IN THE SAFE OPERATION, MAINTENANCE, CLEANING, DISINFECTION AND TROUBLESHOOTING OF DELIVERED EQUIPMENT

____ OTHER: (SPECIFY)

SERVICE / ACTIONS:

____ PATIENT / CARGIVER RECEIVED EQUIPMENT AND INSTRUCTION PER QUALCARE THERAPY CENTER'S POLICIES AND PROCEDURES

___ OTHER: (SPECIFY)

____ EQUIPMENT WILL BE MAINTAINED ACCORDING TO QUALCARE THERAPY CENTER'S POLICIES AND PROCEDURES

COMMENT:

EScience Medical

QualCare Therapy Center

7215 Wyoming Springs, Ste. 600, Round Rock TX 78681
800 Brazos Street, Ste. 1400, Austin TX 78701
TEL: 512.255.2727 FAX: 512.255.6277

DURABLE ASSIGNMENT OF BENEFITS
AND
PAYMENT AUTHORIZATION

Date: _____

Insurance(s): (A photo copy of your insurance card should be attached with this document)

Subject: Patient Name: _____

DOB: _____

To Whom It May Concern:

I, _____, authorize payment of medical service(s) to the provider, EScience Medical (QualCare Therapy Center), or all occasions on which they provide me with covered medical services, including but not limited to PSGs, MSLTs, CPAP Titrations, CPAPs/Bi-Levels, equipment rentals, leases & purchases and other diagnostic testing. This authorization is durable and may only be revoked by an express written request signed by myself. Kindly honor this request to expedite matters for all involved.

Please mail check payable to:

EScience Medical
QualCare Therapy Center
7215 Wyoming Springs, Suite 600
Round Rock, Texas 78681

Thank you.

Effective Date of Authorization: _____ _____
(Signature)

_____
(Print Name)

EScience Medical

QualCare Therapy Center

7215 Wyoming Springs, Ste. 600, Round Rock TX 78681
800 Brazos Street, Ste. 1400, Austin TX 78701
TEL: 512.255.2727 FAX: 512.255.6277

PATIENT REGISTRATION
AUTHORIZATION, ACKNOWLEDGEMENT AND CONSENT

Welcome to our facility. In order to properly serve you, we will need the following information (Please Print.)
All Information will be strictly confidential.

Patient's Name	**Sex** ☐ M ☐ F	**Birth Date** _____/_____/_____	**Marital Status** ☐ Single ☐ Widowed	☐ Married ☐ Divorced
Patient's Address:		**City:**	**State:**	**Zip:**
Home Phone:	**Cell Phone:**		**Patient's Social Security No.**	
If employed, Name of Employer:			**Business Phone:**	
Employer's Address if applicable:			**Occupation:**	
Person Financially Responsible ☐ Self ☐ Name:	**Relationship** ☐ Spouse ☐ Other	**Resp Party's Birth date** _____/_____/_____	**Resp's Social Security No.**	**Resp's Phone No.**

Reason for Visit: ☐ PT ☐ ENG ☐ Sleep Study ☐ Other: _____	**Referring Physician:**	
	Person to Contact in Case of Emergency:	
	Relationship to Patient:	**Emergency Phone Number:**
Primary Insurance (ID Card to be photocopied):	**Secondary Insurance (ID Card to be photocopied):**	

Lifetime Assignments of Benefits/Information Release/Authorization to Treat/Acknowledgement/Consent

I authorize payment of medical benefits to Sleep Science Clinics, LLC. for any services furnished. I understand that I am financially responsible for any amount not covered by my insurance carrier. I authorize you to release to my insurance company or its agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

I also authorize the interdisciplinary team to perform the treatments or procedures approved by my referring physician. I acknowledge that no guarantee, either expressed or implied, have been made to me regarding the outcome of any medical treatments or procedures

I specifically agree to pay finance charge of 1.5% per month (18% per annum) on any balance due over 90 days, and specifically agree to attorney's fees of 25% or greater, as well as all to collection, court costs and interest fees accrued with the collection of this account.

Further, I have received copies and read Sleep Science Clinics, LLC Financial and Payment Policy and Notice of Privacy Practices.

_____ _____

Patient, Parent or Guardian Signature (If patient is under 18 years old) **Date**