ORDER INTAKE 2690 Pennsylvania Ave. Unit #7 Ogden UT, 84401 Office: 385-206-8816

ORDER RECEIVED		**REFERRAL SOURCE**	
Date:		DX - Codes	
PATIENT INFORMATION		Referral contact person:	
Name:	DOB:	Address:	
Address:		City/State:	Zip:
City/State:	Zip:	Phone:	
Phone:	SSN:	Expected discharge date(if applicable):	
INSURANCE INFORMATION	*(copy of Cards)		
Primary:		Secondary:	
ID#:		ID#:	
Address:		Address:	
City/State:	Zip:	City/State:	Zip:
Spouse name:		Spouse name:	
Equipment:			

Delivery setting: Home ALF SNF(prior to discharge) LTAC

Delivery address:____Phone:_______________________

ASSIGNMENT: I hereby assign all my insurance/Medicare/Medicaid benefits to me or on my behalf to Mindful Mobility for any equipment, services, or supplies furnished to me by Mindful Mobility. The assignment will remain in effect until revoked by me in writing. A Photocopy of the assigned is to be considered as a valid original.

RELEASE OF INFORMATION: I authorize my hospital, health-care agency, or holder of medical information including Medicare or other insurance companies to release the information to my health care provider and it's agents to determine benefits payable for my health care or related services. I release all information necessary to secure payment for services I receive.

AUTHORIZED SIGNATURE ____ **DATE** ________________________

PERSON OTHER THAN CUSTOMER SIGNING: ____

(SIGN & PRINT NAME)

REASON IF CUSTOMER IS UNABLE TO SIGN:

PHYSICIAN INFORMATION	U-pin #	Clinic Name:	
Name:		Address:	
Phone:	Fax:	City/State:	Zip:
THERAPIST INFORMATION			
Name:		Phone:	