D&J Medical
ORTHOTICS PROSTHETICS COMPRESSION

Acct #: _____

Ins.#: _____

Compression Order Consent Form

Patient Name: _____ DOB: _____

QTY	R – L – NA	DESCRIPTION	COST

I authorize D&J Compression to fabricate or order the device prescribed by my physician. I agree to accept the device when notified by D&J Compression that it is completed. I agree that my insurance carrier will be billed for this device and that I may be responsible for any charges not covered by my carrier.

Consent for Release of Medical Information:
In order to verify your insurance benefit coverage for compression garments, it is necessary for us to provide our vendors with your personal information. This information will include your name, address, phone numbers, and insurance coverage. It is also necessary for us to provide portions of your insurer in order to facilitate payment. I have received information regarding privacy practices and HIPAA regulations.

Warranty Information:
D&J Compression guarantees that the compression garments being provided to you will be made to your measurements and properly fitted to correspond to your anatomical condition at the time of your visit. When necessary, your garments will be returned for replacement at no charge to you or your insurance company for a period of 15 days from the date of delivery to our office.

For additional information, please visit our website at www.dandjcompression.com

By signing my name below, I certify that I have read and consent to all of the above information.

Patient Signature: Date: _____

Representative/Guardian: Date: _____

FOR OFFICE USE ONLY
DX Code: _____ Practitioner: _____
Delivery Address: _____
Delivery Signature/Tracking Number _____ Date: _____

Please email or fax this form to: Reorders@dandjcompression.com