WOMEN'S HEALTH BOUTIQUE®
DALLAS ~ LONGVIEW ~ OAK CLIFF ~ PLANO

Patient Name_____ **Date of Birth**_____

Physician Certification of Medical Necessity	**Prescription**
Diagnosis/ICD-10 Code_____ **Medical Necessity**_____ _____ **I hereby certify under penalty of perjury that the equipment prescribed herein is medically indicated and , in my opinion, is reasonable and necessary with reference to the accepted standards of medical practice and treatment of this patient's condition.** **Signature** _____ **Print Name**_____	❍ **Post Surgical Camisole x _____** ❍ **Silicone Prosthesis x _____** ❍ **Foam/Leisure/Swim Prosthesis x _____** ❍ **Mastectomy Bra x _____** ❍ **Compression Sleeve x _____** ❍ **Compression Pump _____ mmHg**

Purchase Agreement, Assignment of Benefits, & Authorization to Release Medical Records

The product(s) prescribed above is part of your physician's treatment protocol. The product(s) are supplied by Women's Health Boutique. By accepting this product, you will be liable to Women's Health Boutique for any deductible or co-insurance not paid by Medicare or your insurance company.

1) I acknowledge that I have been instructed in the proper use and care of this product or equipment and received warranty information.
2) I hereby authorize payment(s) to be made directly to Women's Health Boutique and I authorize the release of all information necessary to process any and all insurance claim(s) in order to secure such payments. I understand that I am responsible for all charges for the items prescribed above, and if my insurance company(s) fails to pay Women's Health Boutique in full for any reason, I agree to pay all unpaid balances.
3) Although I may have insurance benefits, this is no guarantee of payment by the insurance provider, and Women's Health Boutique does not make any claims regarding insurance coverage or benefits, and I am responsible for any and all deductible or co-pay amounts, or non-covered items.
4) I acknowledge that I have received a copy of the Medicare Supplier Standards and Privacy Notice, if applicable.

Patient Signature_____ **Date**_____

I accept full responsibility for payment of the product(s) received and request that any payment made by my insurance company be made directly to:
WHBoutique Inc ~ 605 N Sixth St ~ Longview, TX 75601-6606 ~ 800-525-2420

Compression Pump Orientation and Set-Up Checklist

General Use – Reviewed Doctor's orders and prescription. Explained basic operation and use of pump, including pressure and pause settings. Explained emergency contact procedure. Explained warranty information.
Safety – Explained proper grounding procedure regarding electrical safety.
Maintentance – Instructed care, cleaning, and storage of device and sleeves.
Patient Safety Warnings – Explained that patient should not exceed the pressure setting as prescribed by physician.

Customer was given 1) contact information, 2) use, care, safety instructions, and warranty information, and any other applicable paperwork, demonstrating knowledge or the proper care and use of compression pump.

_____ _____
Patient/Caregiver Signature **Date**

_____ _____
WHB Signature **Date**