



Specialized Pulse Oximetry Testing Service

1436 K Yankee Park Place
Dayton, Ohio 45342

Phone(937)433-7768
Fax (937)433-7722

Patient Information Form

PATIENT NAME _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____ COUNTY _____

HOME PH _____ WK PH _____ CELL _____

DOB ___/___/___ Male / Female S / M / W / D SS# _____

DME NAME _____ CITY _____ STATE _____

PHONE _____ FAX _____

PHYSICIAN _____ NPI _____

Medicare # _____ State _____ Primary Secondary

Medicaid # _____ State _____ Primary Secondary

Private _____ # _____ Primary Secondary

Assignment of Benefits

I, the undersigned, certify that I (or my dependent) have insurance coverage as listed above and assign directly to SPOTS all insurance benefits, if any, otherwise payable to me for services rendered. I am financially responsible for all charges whether or not covered by insurance. I also hereby authorize the release of pertinent information to insurance carriers who may require it. I agree to be responsible for any reasonable collection costs and/or attorney fees incurred in collecting a delinquent account. I am responsible to inform SPOTS of any changes in the insurance coverage. I am responsible for payment of any services provided by SPOTS.

Patient signature X _____ DATE _____

Statement of Authenticity

I, the undersigned certify that I am the recipient of the Oximetry testing unit and that the test was actually performed on me at the dates specified below. My identity was verified by the DME provider and I was tested on the settings marked below. I also certify that I have not tampered with or altered this test in any way and that it will be given to the DME courier to be downloaded.

Testing done on RA Oxygen _____ LPM CPAP _____ BIPAP _____

Start Time _____ End Time _____ Time Oxygen put on _____

Patient signature X _____ DATE _____

Medical Release

I, the undersigned authorize SPOTS to use and disclose my health information for the purpose of treatment, obtaining payment, or supporting my healthcare plan. I also authorize SPOTS to fax my results with confidential disclosure to my ordering Physician _____ and the DME provider _____
(Note: Notice of privacy practices is available upon request.)

Patient signature X _____ DATE _____