

San Antonio • 210-614-3804 • fax 210-614-4232 Hondo • 830-741-8171 • fax 830-741-8178



	PATIENT N	FORMATION		
Last Name: First	STATES TO STATE OF STATES	Middle Initial:	DOB:	Male
[- 사람들 회사 시설 <u>- 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - </u>				Female
Address:		City / State / Zip:		
	12 -		Los	
Home Phone:	Ceii Phone:		County:	
S.S.#	Email:			
Maritai Status:	Employment:		Height:	Weight:
Married Single Other				<u> </u>
How did you hear about us?		Email Address:		
and the second s	Constitution of the Consti	YCONVACT		
Name:	Relationship:		Phone:	
Address:		City / State / Zip:		•
	PERDRING	PHYSICIAN		
Physician's Name:	Phone:		City / State:	
INSURANCEINFORM	VilON (If you do not ha	ve insurance, please v	ville in "No Insurance")
Policy Holder Name (if different:)		DOB:	S.S. #	
Address (if different):		City / State / Zip:		
Patient's Relationship to Policy Holder: Self Spouse Child	Other (Specify):			
Primary Insurance:	Policy #:		Group #:	
Secondary Insurance:	Policy #:		Group #:	
Consent for Care/Service: I have been informed about authorize BexarCare/The Pink Boutique to provide h				s from which I may choose
Release of Information: i hereby authorize the release				l during treatment/services
to, from BexarCare/The Pink Boutique, the treating ph authorize BexarCare/The Pink Boutique to review my	ysician(s), payer sources, a	nd/or other medical provide	ers involved with services as	
Assignment of Benefits/Financial Responsibility:	rika di majarangi ita			Boutique and allow
assignment of perentsy mancial responsibility. assignee to release all information necessary to secul BexarCare/The Pink Boutique. I agree that a photoco	re payment. I understand th	at I am responsible for prov	iding current insurance/pay	er information to
legally responsible for all the charges incurred whether	er or not they are paid by my	health insurance, and that	any unpaid balance shall b	e due in full IMMEDIATELY
if insurance proceeds are paid directly to me. Charge payments, out-of-pocket expenses, and non-covered	services. I am aware of the	medical necessity of the se	rvices prescribed by my ph	ysician, and I understand
these services may be deemed unreasonable and not not receive payment from my insurance/payer source	I will be fully responsible fo	r the unpaid charges within	30 days of the invoice date	
45 days of billing date will be assessed late charges.				
Acknowledgment and review of the Patient Bill of Rights, HIPAA Privacy Practices, and the Supplier Standards: I have read and reviewed the Patient Bill of Rights handout, the HIPAA Privacy Practices handout, and the Supplier Standards handout. I understand that I may request a copy of any or all of the handouts				
mentioned above. I have asked for clarification, if nee	ded, regarding the handout	s mentioned above.		
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Mastectomy Clinical Questionnaire

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Date:				
Referring Doctor:	Weight:	Height:		
Fitter:				
MEDICAL HIS	FORY			
Date of last physical exam:				
Date of surgery:				
Was the surgery bilateral or unilateral?				
If unilateral, which side?				
If surgery was done 8 weeks ago, have been released from y		Yes	□No	
Are you currently wearing a breast form?		Yes	□No	
If yes, how long?				
Are you particular in the type of bra that you want?		Yes	□No	
If yes, what would you like in a bra?				
Do you have trouble hooking a bra with a back closure?		Yes	☐No	
TO BE COMPLETED B	Y FITTER			
Band Measurement:	Provide Balance and Arthur Providence and Providence		ernen i konstinen erek er	200 200 EU 00 EE
Cup Measurement:				
Symmetry measurement:				
Assessment Note (any visible scars, rashes, open wounds, et	A \.			
Assessment Note (any visible sears, rashes, open wounds, et	c.,			
Objective Note (what is the goal to be accomplished with too	day's fitting):			
Plan Note (plan for follow up):				
Products sold to the patient have been inspected for defects a	and structural i	ntegrity?	☐ Yes ☐] No

Compression Health History Questionnaire

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Date:			
Patients Name:	Date of Birth:		
Referring Doctor:	Weight:	Height:	
Fitter:			
MEDIC	AL HISTORY		
Have you ever worn compression garments before If yes, please list the type of brand:		Yes	□No
Have you ever been diagnosed with lymphedema? If yes, when:		Yes	No
Have you ever been treated for lymphedema by a the If yes, when:	herapist?	Yes	No
Have you ever been bandaged?		Yes	No
Has your Therapist performed MLD "Manual Lym	ph Drainage"?	Yes	No
Any history of Chemotherapy? If yes, when:		Yes	No
Any history of Radiation? If yes, when:		Yes	No
Do you have a caretaker or someone to help you wi	ith the compression garments?	Yes	No
How long has your swelling been present?			
When is swelling worse (time of day, certain activity	ties, etc)?		
What other medical problems seem to affect it (if an	and the control of the second of the control of the		
What makes it better?			
Are you currently using any alternative methods to		1.0	
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Check the box if you have or have had any syr	mptoms in the following area	s to a signi	ficant degree.
☐ Blood Clots in the Legs	☐ Other Heart Condit		
☐ Pulmonary Embolism	☐ Circulation Problems		
☐ Acute D.V.T.	☐ Skin Condition		
□ Phlebitis	□ Fibromyalgia		
□ CHF (Cardiac Edema)	□ Decrease Energy Le	evel	
☐ Renal Dysfunction	□ Stroke		
☐ Hypertension	☐ Other pain/discomf	ort:	
□ Paralysis	☐ Lymph Nodes Rem		Yes No
□ Diabetes	How Many?		
☐ Cardiac Arrhythmia (A-V Block)			

Physician Prescription

Patient's Name:	DOB						
Insurance:							
ICD-9 Code/Diagnosis:							
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Surgery Side: Left Right Bilateral							
Post Breast Surgery	* 0000						
Post Surgery Silicone Breast Form	L8030	Qty					
Post Lumpectomy Partial Silicone Breast Form	L8030	Qty					
Leisure Form	L8020	Qty					
Post Surgery Bras	L8000	Qty					
Post Surgical Camisole	L8015	Qty					
Monthly Adhesive Supplies—need 12 months	A4280	Qty					
Cranial Prosthesis	A9282	Qty					
Effective Starting Date of this Prescription:							
Estimated length of need (in months, max. allow	ed is 12 m	nonths):					
Has patient needed these supplies continuously since surgery?							
If yes, indicate the date of Surgery:							
Physician's Name:							
Physician NPI:							
Address:							
Office Phone: () Office Fax: (<u> </u>						
Physician's Signature:	Date:						
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