COMPRESSION
CARE CENTER

NOCIF82018

New Online Client Intake Form

Name: _____ DOB: _____
Last *First* *MI* *MM/DD/CCYY*

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #'s: _____ (H) _____ (C)

Are you now or have you ever worn compression garments? ☐ yes ☐ no

if yes, what compression level? ☐ 15-20 mmHg ☐ 20-30 mmHg ☐ 30-40 mmHg ☐ other

I have private insurance and would like someone to check my coverage. ☐ yes ☐ no
if yes, submit 3a and 3b (see below)

Submit the following by email or fax

1. Completed Client Intake Form
2. Physician's Prescription

3a. Copy of insurance card, both front and back (if billing only).

3b. If you are not the primary insurance holder, please provide their DOB with paperwork.

email: new.client@compressioncarecenter.com
fax: 980-320-8298

I affirm that the information I have given is true and complete to the best of my knowledge. I also understand that any and all information may be verified independently at the sole discretion of Compression Care Center, Inc., and I expressly give my permission for such inquiry and verification. All information contained therein is confidential and will only be shared with a third party for insurance and/or billing purposes. My signature also allows permission for the staff of Compression Care Center to contact me by phone and/or email concerning the furnishing of any covered item, if applicable.

Client Signature: _____ **Date:** _____

Thank you! Some one will be in touch with you by the next full business day.