**New Acct.****[ ]**

**Old Acct** **[ ]**

Intake Form

**Referral \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Facility\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone/ext. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Order Date \_\_\_\_\_\_\_\_\_\_\_\_\_ Time \_\_\_\_\_\_\_AM/PM CSR \_\_\_\_\_\_\_\_\_\_\_\_ Delivery Date \_\_\_\_\_\_\_\_\_\_\_\_\_ Time \_\_\_\_\_\_\_\_\_\_\_\_ Discharge Date \_\_\_\_\_\_\_\_\_**

**PATIENT INFORMATION Is this their Primary Address (6mos or >)?** **[ ]  Y** **[ ]  N If No, obtain the primary address and the delivery address**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt# \_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_Zip: \_\_\_\_\_\_\_\_\_\_\_­­\_\_\_ Home Tel #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Tel: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HomeTel \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City & State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Tel # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PHYSICIAN INFORMATION**

Doctors Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ UPIN # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Office Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_ ZipCode \_\_\_\_\_\_\_\_\_\_\_\_ Tel # (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax# (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date last seen by MD: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Hospital/nursing home \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Admission Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Discharge Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Health Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Nurse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE COVERAGE:** **[ ]  MEDICARE** **[ ] MEDICAID** **[ ]  PRIVATE INSURANCE** **[ ] PRIVATE PAY** **[ ]  Insurance Card Verbally Verified**

**Primary Insurance**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Insured Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Policy # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Case Manager \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary Insurance** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Insured Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_ Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Policy # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Case Manager \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Patient aware of co-pay and deductible? [ ] Y [ ] N Explained at time of intake or set-up [ ]  Y [ ]  N

# PRESCRIPTION INFORMATION Patient’s Height: \_\_\_\_\_\_\_in. Weight: \_\_\_\_\_\_\_lb

# Diagnosis 1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date pt last seen by MD\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Supporting clinical notes obtained?\_\_\_\_\_\_\_\_\_\_

RX in hand \_\_\_ will FAX \_\_\_ Coverage? [ ]  Y [ ]  N

# EQUIPMENT ORDERED

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **QTY** | **S = Sale** **R = rental** | **DESCRIPTION** | **HCPC CODE** | **I = Insur****OR****P= Priv Pay** | **PRICE** | **HAS EQUIPMENT BEEN PREVIOUSLY RENTED / PURCHASED?**  |
|  |  |  |  |  |  | [ ]  YES DATE [ ] NO |
|  |  |  |  |  |  | [ ]  YES DATE [ ] NO |
|  |  |  |  |  |  | [ ]  YES DATE [ ] NO |
|  |  |  |  |  |  | [ ]  YES DATE [ ] NO |
|  |  |  |  |  |  | [ ]  YES DATE [ ] NO |
|  |  |  |  |  |  | [ ]  YES DATE [ ] NO |
|  |  |  |  |  |  | [ ]  YES DATE [ ] NO |

1108 New York Ave Unit 1

Saint Cloud, FL 34769

Phone: (407) 337-5112

# Regular Business Hours

# Gateway Medical Supply, LLC is open to the public:

# Monday 9am – 5pm

# Tuesday 9am – 5pm

# Wednesday 9am – 5pm

# Thursday 9am – 5pm

# Friday 9am – 2pm

# Closed each day from 1pm-2pm for lunch.

# Closed Saturday and Sunday

# After Hours Access:

Gateway Medical Supply, LLC can be reached 24 hours a day by email at Gatewaymedicalfl@gmail.com. Once message has been sent an office staff will respond in a timely fashion.

# Emergency Contact Number:

If dealing with a medical emergency please call 911 or go to your nearest hospital. When dealing with a Gateway Medical Supply, LLC emergencies we can be reached at 1-407-337-5114, which will be a direct line to the Compliance Officer.

**Repair & Return Policy**

**At Gateway Medical Supply, our goal is 100% customer satisfaction. If you need to process a return with us, please adhere to the below return policy.**

**Our return policy is as follows:**

Purchased item:Items that are purchased outright may be returned within 30 days if the item is found to be defective, substandard or inappropriate for the indicated use. The item being returned must be the original, new and unused condition. Custom orders may not be returned unless defective, substandard.

Supplies and consumables: Supplies and consumables provided by Gateway Medical Supply may be returned within 7 days of the date of the delivery if deemed to be inappropriate or unnecessary. Defective or incorrect supplies may be exchanged within 30 days of the date of delivery. All supplies being returned or exchanged must be in the original sealed package.

Personal Care Items: Personal care items may not be returned once opened. Please inspect the item at the time of delivery to ensure it meets your satisfaction.

**Service and Repair Policy:**

Replacement or repair of an item that has been misused or abused by the patient or patient’s caregiver will be the responsibility of the patient.

Our return address for approved returns:

Gateway Medical Supply, LLC

Attn: Returns Department

5351 Costa Del Sol Drive

Saint Cloud, FL 34771

We can also be reached by phone at (407) 377-5112 Monday-Friday from 9am-5pm EST.