DAUTERMAN
HEALTHCARE & MOBILITY

1350 S King Street Ste 101
Honolulu, Hawaii 96814
Phone: (808) 591-8860
Fax: (808) 591-8869
Toll Free: (800) 808-9313
www.dautermanmedical.com

CUSTOMER INFORMATION SECTION

Customer Number: (leave blank) Gender: Male Female:
Customer Name: Date of Birth: / /
If Customer is a Child, Parent's Name or in care of:
Customer Address:
City: State: Zip:
Phone Number (home): Phone Number (work):
Fax Number Email address:
Social Security Number : Medicare Number:

ADDITIONAL CUSTOMER INFORMATION SECTION

Employed By: Present Position:
If Married, Spouse's Name:
Spouse Employed by: Present Position:
Referred By:
Nearest Relative's Name: Relationship:
Relative's Address:
City: State: Zip:
Relative's Phone Number (home): Phone Number (work):

Are you currently being seen by a Home Care Nurse? Yes No
If Yes what is the Nurse's name? Agency:

INSURANCE INFORMATION SECTION

Health Insurance Co:
Address of Insurance Co:
Health Insurance Policy Number: Group No:
Name of Policyholder:
Name of Physician: Phone No:
NPI No: Fax No:

CONDITION INFORMATION SECTION

Malady : COLOSTOMY ILEOSTOMY ILEOCONDUIT
(Check all that apply) PARAPLEGIA QUADROPLEGIA FISTULA
Is this condition Temporary? Yes No Other:

PLEASE TURN OVER AND SIGN

CONDITION OF SALE:
Bills are to be paid in 30 days. If not paid in 30 days, a late charge of 1.5 percent of the overdue balance per month will be added to your account. Any overdue balance will affect your credit rating with Dauterman Healthcare & Mobility.

A charge of $ 12.50 will be assessed your account for any check returned by the bank. If a second NSF check Is received, your personal checks will no longer be accepted. Cash, Money Order, Cashier's Check, or Charge Card will be honored only.

If your balance is not paid within 90 days and no effort on your part has been made to arrange for payment, collection efforts will commence and all collection fees will be added to your account.

TRANSPORTATION:
Orders are available for WILL CALL at our King street store during normal business hours. We also offer to mail your order to you should you not be able to pick it up. We normally ship your orders with the U.S. Post Office via PRIORITY MAIL at the postal rate.

We can also ship your order via UPS on special request. UPS shipping rates will apply to the order.

Upon delivery of the goods to the carrier, all risk of loss and other incidents of ownership are passed on to the buyer.

While we do not have a minimum order, a Special Handling Fee of $ 1.00 is applied to orders under $ 10.00 that require shipping.

RETURNS:
No returns for any reason will be accepted without authorization first from this office. All returns must be accompanied with a receipt and will only be accepted provided the merchandise is in full cartons undamaged and in salable condition

Merchandise that is returned within 30 days will receive full credit. After 30 days, merchandise will receive full credit at net cost less 20% restocking charge. Returns after 90 days will not be accepted.

When ordered or shipped in error, full credit is given if returned within 30 days from date of invoice, freight paid. After 30 days, full credit less 20% restocking charge is given. Any returns over 90 days from date of purchase will not be accepted.

Bathroom mobility aids and incontinent supplies are not returnable due to health regulations.

All sales are final on powered mobility items: Scooters, Powerchairs and Lift Chairs.

INSURANCE CLAIM FILING:
Dauterman Healthcare & Mobility will file Medicare and Medicaid insurance claims. HCFA 1500 forms will be made available for customers with other insurance coverage.

Dauterman Healthcare & Mobility does not participate with Medicare, but may accept assignment on a claim by claim basis.

"For insurance claim filing purposes, I authorize any holder of medical information about me to be released to the Health Care Financing Administration, Insurance Agency and its agents any information needed to determine these benefits or the benefits payable for the related services. I request that any authorized insurance payments be made to me. If Dauterman Healthcare & Mobility accepts assignment on any of my insurance claims, I request that payment of authorized insurance benefits be made on my behalf to Dauterman Healthcare & Mobility for any services furnished me."

Signed:_____ Date:_____

Please initial below stating you have received the following:

Initial:_____ Notice of Privacy Practices (HIPPA)

Initial:_____ Medicare Complaint Resolution Policy

Initial:_____ CMS Medicare DMEPOS Supplier Standards

Initial:_____ Safety At Home