essential control systems

ORDERING INSTRUCTIONS
1) COMPLETE this form and have patient **SIGN**
2) FAX completed Order Form to **901-791-9499**
3) ORDER CONFIRMATION will be sent to clinician
4) Call 800-537-3779 with any questions.

HOME BIOFEEDBACK ORDER FORM

TODAY'S DATE_____
DESIRED DATE OF DELIVERY (end of day)_____

CONTRACT TYPE
□ RENTAL
□ PURCHASE

SHIPPING METHOD
□ GROUND=$12
□ 3 DAY= $18
□ 2 DAY=$25
□ OVERNIGHT=$45

SHIP TO LOCATION
□ CLINICIAN OFFICE
□ PATIENT HOME

PATIENT INFORMATION: Shipping address

_____ □ Male □ Female
Last Name First Name

Address

City State Zip

( ) ( ) ( )
Home Phone Work/Daytime Phone Mobile Phone

Email address:

ADDITIONAL PATIENT INFORMATION (Helpful in assisting patients for insurance reimbursement)

_____ _____ / / _____
Diagnosis Code Patient Date of Birth (mo/day/yr)

DISPENSING CLINICIAN

Name
Facility
Address
City State Zip
Phone Fax

PRESCRIBING PHYSICIAN (required for claim form)

Name
Facility
Address
City State Zip
Phone **UPIN# / NPI#**

PRODUCT INFORMATION (please circle/complete this section for accurate order filling)

Which biofeedback unit does patient need? U-Control TR-10 TR-20 Other_____

Does patient need an internal sensor? Vaginal Anal None Brand Name?_____

If "NONE", what sensor does patient already have? Vaginal Anal Not Using Internal Sensor

What is the Brand Name of the sensor they already have? _____

Does the patient need any other supplies? Surface Electrodes Extension Cables Adapter

FINANCIAL RESPONSIBILITY & PAYMENT INFORMATION

Essential Control Systems **does NOT accept assignment** of private insurance for the rental or purchase of biofeedback home units. We will, however, assist patients in filing insurance forms. We expect payment on all accounts to be made by the patient at the time of service. By signing below, I understand and agree to the above terms and authorize my credit card to be charged in accordance with the above terms. All patients must provide credit card information even if third party payment is anticipated. **** Please use this space to provide billing address for credit card if it is different than the shipping address.**

_____
Patient Credit Card No. Exp Date ***security code*** Patient/Cardholder Signature