Today's Date _____

# Karen Nevins PT, LLC

Compression Garment Fitter

## PATIENT INFORMATION

Name_____

**Street Address:** _____

City: _____ State: _____ Zip: _____

**Telephone Information**

Home: _____ Cell: _____ Work:_____

**Email Address:**_____

**Gender:** Female ___ Male ___

**Date of Birth:** Month _____ Date _____ Year ____

## REFERRAL INFORMATION

Referring Physician Name:_____

Clinic:_____

If you were not referred by your physician, who can we thank for the referral?

_____

## PAYMENT DUE

I understand that payment is due at when services are rendered and all garments will be pre-paid BEFORE they are ordered. There will be NO insurance claims submitted for any service or garment. It is my responsibility to verify my benefits and submit claims myself.

**Patient Initials:** _____ **Date:** _____

## REFUNDS/RETURNS

Items showing visible signs of wear are non-returnable, and non-refundable. Custom garments can NOT be returned, but can be altered at no charge within thirty days of purchase. There are no refunds or returns on custom garment orders.

**Patient initials:** _____ **Date:**_____