

Chino Medical Supply
12422 Central Ave
Chino, CA 91710
Ph: 909-464-1500
Fax:909-464-1570

INVOICE

| SALESPERSON | ACCN # | CUST. PHONE # | ORDER DATE | DELIVERY DATE |
|-------------|--------|---------------|------------|---------------|
| | | | | |

| SHIP TO | RESPONSIBLE PARTY |
|-----------------------|-------------------|
| | |
| INSURANCE INFORMATION | DOCTOR |
| | |

| MANUF. | ITEM/LOT# | DESCRIPTION | BILLING CODE | QTY | UNIT PRICE | EXT. | PT. COPAY @ 20% |
|--------|-----------|-------------|--------------|-----|------------|------|-----------------|
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| | | | | | | | |
| | | | SALES TAX | | | | |
| | | | TOTAL | | | | |

Medicare or my insurance has not purchased or rented same or similar items stated above. _____ (initials)

DELIVERY TIME: _____

___Delivery

___Pickup

Contact Made _____

DELIVERY TECH: _____

___ I HAVE READ THE RIGHTS & RESPONSIBILITIES AND AGREE TO ABIDE BY THEM.

___ Basic home safety assessment performed, client informed of real or potential hazards _____DT initials. List hazards discovered above in comments section.

___ Electrical ground check performed _____DT Initials ___Ground OK ___ Improper Ground * Please refer to instructions on back regarding proper electrical grounding.

Please notify of any shortage or discrepancies within 3(three) days of receipt of goods or no credit will be allowed. MERCHANDISE CONTAINED IN THIS SHIPMENT HAS BEEN CAREFULLY COUNTED AND CHECKED. PLEASE CALL OR WRITE REFERRING TO YOUR ACCOUNT NUMBER IN THE EVENT OF ANY DISCREPANCIES. THANK YOU!

I ACKNOWLEDGE RECEIPT OF EQUIPMENT AND/OR SUPPLIES LISTED ON THIS ORDER, AND ALSO I ACKNOWLEDGE THAT I HAVE BEEN FULLY TRAINED ON EQUIPMENT.

Authorization to Assign Benefits to Provider & Release of Medical Information: I request that payment of authorized Medicare, Medicaid, or other private insurance benefits be paid directly to the above named company for any services furnished me by that supplier. I further authorize a copy of this agreement to be used in place of the original and I authorize any holder of medical information about me to release to the CMS and Accreditation Company and its agents, any information needed to determine these benefits or the benefits payable to related services. Thank You!

ATTENDANT SIGNATURE

(If patient is unable to sign)

RELATIONSHIP

DATE

CUSTOMER SIGNATURE