Compression Garment Proof of Delivery

Patient Name:	Placeholder Name
Patient Date of Birth:	Placeholder Date of Birth
Insurance:	Placeholder Insurance
Date:	December 30, 2024

I request that payment of authorized Medicare benefits (or other third-party insurance) be made either to me or on my behalf to Central Coast Lymphedema for any services furnished for me by that company. I authorize any holder of medical information about me to release to the Health Care Financing Administration (or other Insurance Administrations) and its agents any information needed to determine these benefits or the benefits payable for related services. Please be aware that Central Coast Lymphedema and Wound Center is not liable for any injuries or complications resulting from the improper use of garments or other equipment provided. It is important to follow all usage instructions and consult with a healthcare professional for any concerns regarding the use of these items.

Signature: _____