Intimate Image
Necessary Basics Boutique
intimateimage.com

Customer Information
Insurance Verification Form

Referred By:

Last Name:_____	First Name:_____	Initial:_____	DOB:_____
Address: _____			
City/_____	State:_____	Zip Code:_____	
Email Address: _____ ☐ Please add my name to your mailing list *			
Home Phone:_____	Alternate Phone:_____		
You may leave phone messages for me @ _____			
PHYSICIAN: _____	NPI NUMBER:_____		
Phone:_____	Fax:_____		
MEDICARE ONLY:			
City:_____	State:_____	IN PECOS? ___ YES	
PRIMARY INSURANCE:_____	Phone Number:_____		
Member ID#:_____	Group#:_____		
Policy Holder:	☐ Self	Other:_____	
SECONDARY INSURANCE:_____	Phone Number:_____		
Member ID#:_____	Group#:_____		
Policy Holder:	☐ Self	Other:_____	
DATE OF SURGERY: ____/____/_____	SURGERY SIDE: _____Left _____Right		
☐ Lumpectomy	☐ Mastectomy	☐ Any Lymph Node Removal	
☐ Reduction	☐ Reconstruction	☐ Other _____	
☐ Chemotherapy	☐ Radiation Therapy		
Any Further Breast SurgeryType: _____	Date: _____	Prognosis: _____	

I HAVE RECEIVED A COPY OF INTIMATE IMAGES' HIPAA PRIVACY NOTICE	_____ Initials
I WILL BE FINANCIALLY RESPONSIBLE FOR ALL PURCHASES, CO-PAYS AND UPGRADES THAT ARE NOT COVERED BY MY INSURANCE.	_____ Initials
I HAVE RECEIVED PRODUCT WARRANTY, CARE AND STORAGE (if applicable)	_____ Initials
I HAVE RECEIVED A COPY OF MEDICARE PROTOCOL/RESOLVING COMPLAINT FORM (if applicable)	_____ Initials
UPON REQUEST, I CAN OBTAIN A COPY OF THE MEDICARE SUPPLIER STANDARDS (if applicable)	_____ Initials
48 HRS RETURN POLICY ON BRAS & PROSTHESIS	_____ Initials

I UNDERSTAND THAT INTIMATE IMAGE IS A SPECIALTY RETAIL BOUTIQUE / STORE . INFORMATION GIVEN IS TO SUPPORT MAKING LINGERIE DECISIONS AND IS IN NO WAY INTENDED TO REPLACE MEDICAL ADVICE FROM MY PERSONAL HEALTHCARE PROVIDERS. INTIMATE IMAGE MAKES NO CLAIM OR WARRANTY, OTHER THAN MANUFACTURER'S GUARANTEE OF WORKMANSHIP.

INTIMATE IMAGE WILL BILL MY PRIMARY INSURANCE CARRIER AS A COURTESY. I WILL BE RESPONSIBLE FOR CO -INSURANCE, CO - PAYMENTS, UPGRADES AND DEDUCTIBLES. I MAY EVEN BE RESPONSIBLE FOR THE ENTIRE PURCHASE IF MY CARRIER DENIES THE CLAIM OR MY COVERAGE IS IN QUESTION. I UNDERSTAND THAT ANY AND ALL BALANCES OWING TO INTIMATE IMAGE AFTER PAYMENT BY MY PRIMARY INSURANCE CARRIER, IS DUE THIRTY (30) DAYS AFTER BILLING DATE AND AGREE TO PAY A SERVICE CHARGE OF 1-1/2 % ON ACCOUNT BALANCES FOR MORE THAN THE ABOVE - MENTIONED THIRTY (30). IF THE DELINQUENT ACCOUNT IS PLACED IN THE HANDS OF A COLLECTION AGENCY , I FURTHER AGREE TO PAY THE COLLECTION AGENCY FEE NOT EXCEEDING THIRTY PERCENT (30%).

I REQUEST PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF TO INTIMATE IMAGE FOR SERVICES RENDERED BY THIS PROVIDER . I AUTHORIZE ANY MEDICAL INFORMATION CONCERNING ME TO BE RELEASED TO INTIMATE IMAGE, OR TO THE HEALTH CARE FINANCING ADMINISTRATION (HCFA) AND ITS AGENTS, ANY INFORMATION NEEDED TO DETERMINE BENEFITS OR BENEFITS PAYABLE FOR RELATED SERVICES.

DATE:_____ SIGNATURE OF BENEFICIARY /PATIENT: _____

3/25/2013