

AeroChamber & Peak-Flow Meter Order Form

Fax to 501-663-6668. We'll take care of the rest. Form also available at: finneganhealth.com/forms

1 PATIENT INFORMATION

Name: _____

Date of Birth: _____ Sex: M or F

Phone #: _____

Email: _____

Address: _____

City/State/Zip: _____

Parent/Guardian Name: _____

Relationship to Patient: _____

Medicaid #: _____

Insurance Company: _____

Phone #: _____

Policy #: _____ Group #: _____

PATIENT DIAGNOSIS

493.9, Asthma **Other:** _____

SHIP ORDER TO (check one):

Clinic Address Patient Address Pick Up at FHS

EQUIPMENT NEEDED (check one):

- Small Z-Stat Chamber w/ mask (orange)
- Medium Z-Stat Chamber w/ mask (yellow)
- Large Z-Stat Chamber w/ mask (blue)
- Z-Stat Chamber no mask (blue)
- Peak-Flow Meter Only

2 CLINIC INFORMATION

Physician's Name: _____

Clinic: _____

Address: _____

City/State/ZIP: _____

Phone #: _____

NPI #: _____

3 AUTHORIZATIONS

M.D., APN, or PA SIGNATURE + DATE:

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PATIENT SIGNATURE + DATE:

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Finnegan Health Services is committed to protecting your private health information (PHI). For a copy of our privacy act/patient bill of rights, call or write us. By signing above, you authorize us to bill Arkansas Medicaid & give us permission to disclose your PHI to provide & collect payment for these services.