

# 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](http://finneganhealth.com/forms)

## 1 PATIENT INFORMATION

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex:  M  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. SIGNATURE + DATE:

.....

PATIENT SIGNATURE + DATE:

.....

*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.*

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