Joint Commission
on Accreditation of Healthcare Organizations

APGUARD MEDICAL

Office (800) 684-0299
Fax (818) 713-0879

Apguard Medical, Inc.

INVOICE

Customer Name_____ Contact Name_____

Address_____ Phone _____

City_____ Zip_____ Date_____ Time_____

Referral Source_____ Phone_____ Name_____

Physician's Name_____ Phone_____

Qty	**R**ental **P**urchase	**P**ick-up **D**elivery	Product Description	Serial/Lot #	Price/Each

Terms and Conditions

Proof Of Delivery: I acknowledge receipt of the above products and equipment in good working order. I have received instruction in the safe and proper use of the equipment, including cleaning and maintenance requirements.

Assignment Of Benefits/Financial Policy: I acknowledge receipt and I understand the APGUARD MEDICAL, INC. Financial Policy. I authorize release of medical information as necessary to justify the need for medical equipment and authorize payment to be paid directly to APGUARD MEDICAL, INC. I agree, whether I sign below as an agent or a customer, to accept all financial responsibility for the medical equipment furnished to me or the customer by APGUARD MEDICAL, INC. A copy of this agreement may be used in place of the original.

Rights And Responsibilities, Plan of Care/Instructional Checklist, and Privacy Notice: I acknowledge receipt and I understand the APGUARD MEDICAL INC. Patient/Client Bill of Rights and Responsibilities, Plan of Care/Instructional Checklist and Notice of Privacy Practices.

Customer Signature **X**_____ Date_____ Apguard Rep_____
If not the customer above:

Print Name_____ Relation To Patient_____