Aerosol Plus, Inc.
792 Folly Road
Charleston, SC 29412
(843) 795-6452
Toll Free: (877) 795-6452

RENTAL & PURCHASE AGREEMENT

Date: ______________________________

Patient Name (Last, First, MI): ____

Sex: M ☐ F ☐ Date of Birth: ______________________________

Address: ____

City/State/Zip: ____

Phone: ( ) ________________________ Diagnosis: __________________________ ICD: ______________

Primary Insurance: ____ Policy/Group #: ________________

Secondary Insurance: ____ Policy/Group #: ________________

Parent/Guardian (if patient is a minor): ____

Physician Name: ____

Physician Address: ____

City/State/Zip: ____

Phone: ( ) ________________________ UPIN/NPI#: ________________________

Contact Person: ____ Title: ________________________

Patient Information

- I understand that if my insurance coverage is denied, I am responsible for payment of all charges.
- I authorize the release of all medical records needed in relation to the services provided to me.
- I request that a payment be made on my behalf to Aerosol Plus, Inc. by my insurance company, or other payer source (Medicaid, etc.).

Patient/Parent/Guardian Signature: ____ Date: ___________

Physician Information

☐ Check box to indicate patient has received instructions on use of equipment
- Please attach a copy of the Patient/Parent/Guardian Insurance or Medicaid/Medicare Card (both sides)
- Please complete a Certificate of Medical Necessity as required
- Fax to **(877) 795-6453**

Items Dispensed

☐ Stationary Compressor
Serial # ________________
Adult | Pediatric
(circle)
☐ Mask
☐ Peak Flow Meter

☐ Portable Compressor
Serial # ________________
w/Battery | w/o Battery
(circle)
☐ Reusable Nebulizer
☐ Holding Chamber

White Copy – Aerosol Plus Yellow Copy – Physician Pink Copy - Patient