



MEDICAL FORM FOR CRITICAL CARE



Customer Information

DATE: _____

CUSTOMER NAME: _____

SERVICE ADDRESS: _____

MAILING ADDRESS (if different): _____

PHONE: _____

ACCOUNT #: _____

Secondary Contact

NAME: _____

RELATIONSHIP: _____

PHONE: _____

Completed by Patient's Physician

PATIENT'S NAME _____

PHYSICIAN'S NAME _____

PHYSICIAN'S ADDRESS _____

PHYSICIAN'S PHONE _____

TX MEDICAL BOARD LICENSE # _____

PHYSICIAN'S SIGNATURE: _____ DATE: _____

PATIENT'S SIGNATURE: _____ DATE: _____

QUALIFICATIONS PURSUANT TO THIS FORM DO NOT GUARANTEE AN UNINTERRUPTED POWER SUPPLY. IF ELECTRICITY IS A NECESSITY, PATIENT/CUSTOMER MAY NEED TO MAKE OTHER ARRANGEMENTS. REASONABLE EFFORT WILL BE MADE TO EXTEND THE DATE FOR DISCONTINUANCE OF SERVICE TO A DELINQUENT RESIDENTIAL CUSTOMER IF ESTABLISHED THAT DISCONNECTION WILL RESULT IN A PERSON RESIDING AT THE CUSTOMER'S RESIDENCE BECOMING SERIOUSLY ILL. PROPER DOCUMENTATION MUST BE PROVIDED AND CUSTOMER MAY ENTER INTO A DEFERRED PAYMENT AGREEMENT. FAILURE TO MAKE TIMELY PAYMENT AND/OR MAKE PAYMENT ARRANGEMENTS WILL RESULT IN DISCONNECTION. IF DISCONNECTED AFTER FAILURE TO REACH AN AGREEMENT OR MEET THE DEFERRED PAYMENT AGREEMENT, RECONNECTION WILL NOT BE MADE UNTIL OUTSTANDING BALANCE AND FEES ARE PAID IN FULL.

This document is valid for one year from date of document.