

i-port Patient Acknowledgement Form

This form must be completed and returned **with your prescription** to Diabetic Promotions before your order for the i-port Injection Port can be processed.

Patient Name: _____

Patient Address: _____

Patient Phone: _____

Physician Name: _____

Physician Address: _____

Physician Phone: _____

I acknowledge that the i-port Injection Port (Diabetic Promotions item #IPORT) cannot be returned to Diabetic Promotions for a refund or credit. I understand that the manufacturer of this item, Patton Medical Devices, may or may not have a warranty on this item. I also understand that there is information regarding this item, including any warranty, available online at www.i-port.com and www.pattonmd.com.

Patient (or Guardian) Signature: _____

Please mail completed form and prescription to:

Diabetic Promotions
P.O. Box 5400
Willowick, OH 44095-0400