Prosthetic & Orthotic Solutions, LLC.

Assignment of Benefits, Consent to Release Information, & HIPAA Acknowledgement

(Patient's Printed Name) Patients Date of Birth **MRN#** (office use)

I request that payment of authorized Medicare, Medicaid, or private insurance benefits be made to Prosthetic & Orthotic Solutions, LLC for any covered services furnished by Prosthetic & Orthotic Solutions, LLC. I agree to pay to Prosthetic and Orthotic Solutions, LLC the deductible and/or coinsurance on my claim. I understand and agree that I am responsible for the following expenses; any service my insurance plan deems "non-covered", all coinsurance and/or co-payment amounts, all deductibles, any amount that exceeds benefit limits under my insurance plan and any amount my insurance plan deems not covered because I was not insured on the date of service. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents, Champus/TRICARE and its agents, or any private insurance company any information needed to determine these benefits or the benefits payable for related services.	
HIPAA	**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, and the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you to read it carefully and completely before signing this Consent. **Purpose of Consent:** By signing this form, you consent for Prosthetic & Orthotic Solutions, LLC. to use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations
Medicare Supplier Standards	The products and/or services provided to you by Prosthetic & Orthotic Solutions, LLC. are subject to the supplier standards contained in the Federal regulations shown at 42 Code of Federal Regulations Section 424.57(c). These standards concern business professional and operational matters (e.g., honoring warranties and hours of operation). The full text of these standards can be obtained at http://ecfr.gpoaccess.gov. Upon request, we will furnish you a written copy of the standards.
Assignment of Benefits	I authorize my insurance company to pay benefits directly to Prosthetic & Orthotic Solutions, LLC. I understand my insurance company may not pay for services that are not a covered benefit or are not considered medically necessary. I also understand that there may be benefit limitations with no-fault carriers as deductibles and benefit maximums may apply. I agree to be financially responsible for all services provided by Prosthetic & Orthotic Solutions, LLC.
Communication	I authorize Prosthetic & Orthotic Solutions, LLC. to leave messages on my home phone, and cell phone. I further authorize Prosthetic & Orthotic Solutions to contact me by mail or email.

I have read, understood, and herby agree to all the terms stated above.

Patient or Responsible Party Signature Date

If Responsible Party, please complete below:

Printed Name

Address

Relationship to Patient

For Notice of Privacy Practices only, describe the Responsible Party's authority to act on behalf of the patient.

Patient Questionnaire

Is your injury related to an auto accident or a worker's comp claim?	☐ Yes	☐ No
Are you Diabetic?	☐ Yes	☐ No
Are you allergic to latex?	☐ Yes	☐ No

Height: ______________

Weight: ______________

Designation Disclosure

Would you like to designate Certain Relatives, Close Friends and other Caregivers as Personal Representatives? For example, if you'd like us to be able to speak with your significant other please list them below. If this person is listed below, you further understand that Prosthetic & Orthotic Solutions, LLC. may disclose certain health information to them. The office will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

Name		Date of Birth	Relation
Address	City	State, Zip	Phone Number

Please check Yes or No to all that apply

Emergency contact? ☐ Yes ☐ No **Responsible Party?** ☐ Yes ☐ No **Power of Attorney** ☐ Yes ☐ No

Name		Date of Birth	Relation
Address	City	State, Zip	Phone Number

Please check Yes or No to all that apply

Emergency contact? ☐ Yes ☐ No **Responsible Party?** ☐ Yes ☐ No **Power of Attorney** ☐ Yes ☐ No

I certify that the answers to the questions above and designee information is true, accurate and complete.

Patient or Responsible Party Signature Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, Warranty Policy, Payment & Policy agreement, Patient Bill of Rights, and Supplier Standards but acknowledgement could not be obtained because:

- ☐ Patient or Responsible Party refused to sign
- ☐ Patient was physically unable to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ Other (Please Specify)

Employee Signature	Employee Name
Job Title	Date