Release of Information/Consent Form

ASSIGNMENT OF BENEFITS

The customer requests that payment of authorized insurance benefits be made on the customer's behalf to Advanced Orthotics & Prosthetics for any services furnished.

The customer understands the signature requests the payment by the insurance carrier be made directly to Advanced Orthotics & Prosthetics.

MEDICAL INFORMATION RELEASE AUTHORIZATION

The customer authorizes any holder of medical information about the customer to be released to Advanced Orthotics & Prosthetics or agents of information needed to determine benefits or the benefits payable for related services. The customer understands that the below signature authorizes release of medical information necessary to pay the claim.

FINANCIAL RESPONSIBILITY CONSENT

The undersigned agrees to assume financial responsibility for any claim or portion of the claim thereof, due to Advanced Orthotics & Prosthetics for services provided, and not covered by the insurance policy as of the date listed below. If the insurance company denies coverage for a product/service, the undersigned will assume financial policy responsibility for payment. The undersigned acknowledges the responsibility for any payments not received from the insurance carrier within thirty (30) days from the date of service.

Customer Signature:____ Date: ____________________
(Parent, Guardian or Authorized Signature Accepted)

Please Print Name:____