Patient Consent and Acknowledgment Form

Patient First Name *	Last Name *	Date of Birth *
Insurance Number	Insurance Group Number	Social Security Number

NOTICE OF PRIVACY FOR PROTECTED HEALTH INFORMATION

I have been given a copy of Bionic Prosthetics and Orthotics Notice of Privacy Practices and understand these rights. I also understand that it is my responsibility to notify the Privacy Officer in writing of your restrictions to my patient file. Forms are available through the Privacy Officer upon request.

NOTICE OF MEDICARE SUPPLIER STANDARDS

I have been given a copy of Bionic Prosthetics and Orthotics Notice of Medicare Supplier Standards

CONFIDENTIAL COMMUNICATIONS

I hereby consent and grant permission for Practitioner's employed by Bionic to discuss my medical treatment for orthotics and/or prosthetics, with my referring physician, primary care physician, physical therapist, occupational therapist, hospital and/or rehabilitation staff, relating to my care and treatment. I also understand that it is my responsibility to notify the Privacy Officer in writing of any restrictions to my patient file. Forms are available through the Privacy Officer upon request.

OFFICE PROCEDURES

I hereby give consent to Bionic to provide treatment service(s) the assigned Provider may deem necessary. I understand that I am responsible for payment of charges and that payment is due at the time of service, or I hereby assign insurance benefits to be paid directly to Bionic for professional fees. I understand that I am responsible for charges not covered by my insurance policy. I understand that any amounts which are past due are subject to a 1.5% late fee per month and could be turned over to an attorney for collections, unless prior arrangements have been made with the Business Administrator. Attorney fees and court costs are recognized to be my (the patient/responsible party(s)) responsibility. I understand that I am responsible for a fee of $40.00 for any returned check(s).

RELEASEOF INFORMATION and AUTHORIZATION

I hereby consent and permit a copy of this authorization and assignments to be used in place of this original signed document. I understand that this original will be placed in my patient file to be kept at the medical provider's office. I hereby authorize any practitioner examining and/or treating me, to release to any third party (such as an insurance company or governmental agency) any medical information and records concerning the diagnosis and treatment when requested for use in determining payment of claims. I understand that this is a Lifetime Release of Information unless I have placed restrictions in my patient file and have completed the necessary forms. I hereby consent and authorize Bionic Prosthetics and Orthotics to file medical claims for treatment, electronically or manually, to my insurance carrier(s) for services rendered to me.

ASSIGNMENT OF BENEFITS

I hereby consent and authorize payment to be paid directly to provider, Bionic Prosthetics and Orthotics Group LLC, for services rendered for any orthotic and/or prosthetic services and treatment. Any services for which assignment is not accepted are acknowledged as being my full and complete financial responsibility.

I have read, understand and agree to all of the above.

_____	_____	_____
Patient's Signature*	**Patient's Printed Name***	**Date Signed***
_____	_____	_____
Representative's Signature	Representative's Printed Name/Relationship	Date Signed