O & P Services Inc.
CONSENT FORM

Client Name_____ Chart#_____

CONSENT TO TREAT AND INFORMATION/LIABILITY RELEASE

The undersigned hereby authorizes, grants and/or gives consent to O & P Services Inc. /and representatives including Suzanne O'Connor, CPO, LPO, FAAOP to:
Perform evaluation and/or treatment services
Contact other professionals regarding my/my child's condition while undergoing evaluations
And/or treatment by O & P Services Inc. /and representatives.

The undersigned hereby releases O & P Services Inc./and its employees and volunteers from any and all liability, claims or suits which may result from my/my child's participation in the program provided by O & P Services Inc.

AUTHORIZATION OF ASSIGNMENT OF BENEFITS & RECORDS RELEASE

I hereby assign, transfer and set over to O & P Services Inc. all my rights, title and interest to my medical reimbursement benefits under my insurance policy/ies for services by O & P Services Inc.
I authorize O & P Services Inc. to release, when requested by my insurance company, any medical records with respect to my/my child's medical history at O &P Services Inc. a Photostat copy of this authorization shall be considered as effective and valid as the original.

FINANCIAL AGREEMENT

Financial agreement is attached and forms part of this Consent to Treat and Financial Agreement.

SUPPLIER STANDARDS

The products and/or services provided to you by O & P Services Inc. 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.

NOTICE OF PRIVACY PRACTICES

We are committed to protecting your privacy and ensuring that your health information is used and disclosed appropriately. The Notice of Privacy Practices identifies all potential uses and disclosures of your health information by our practice and outlines your rights with regard to your health information. Your signature below acknowledges that you have received this notice.

IN CASE OF EMERGENCY

I understand that I must and do give permission to O & P Services Inc. to arrange emergency medical treatment for me/my child at a hospital and to release information from my/my child's chart if needed for such medical treatment in case I cannot be contacted. I authorize to contact the following person if I am not available.

_____

Name Relationship to Patient Phone #

PATIENT COMMUNICATION

I hereby give permission to ***O &P Services Inc.*** to contact me via phone, mail, or email to discuss any information regarding my medical condition(s) and treatment(s) related to my prosthetic and orthotic management or needs.

Preferred Contact Phone Number_____

(Please initial your choice)

_____ OK to leave a message with detailed information.
_____ Leave a message with call-back number only.

I have read, understand and agree to the above for services rendered by O & P Services Inc.

_____ _____

Patient Signature/ Legal Guardian Date