

Professional Orthotic & Prosthetic Services, LLC

HIPAA Release/Consent Form 2021

Assignment of Benefits

The patient requests payment of authorized insurance benefits made on the patient's behalf of Professional Orthotic & Prosthetic Services, LLC, for any services furnished. The patient understands their signature request the payment by insurance carrier be made directly to Professional Orthotic & Prosthetic Services, LLC.

Medical Information Release Form Authorization

The patient authorizes Professional Orthotic & Prosthetic Services, LLC to release information needed to determine benefits. The patient understands the below signature authorizes the release of medical information to necessary health care professionals in order to provide the proper services and collections of billable claims. The patient authorizes Professional Orthotic & Prosthetic Services, LLC to release information and or photographs to physicians, rehabilitation centers, physical therapist, and other medical staff involved in his/her healthcare. The patient also agrees the images and information accompanying them are the property of Professional Orthotic & Prosthetic Services, LLC has no financial obligations to the patient and/or representatives of the patient.

Financial Responsibility Consent

The patient and/or the guardian agrees to assume financial responsibility for any claim or portion of claim due to Professional Orthotic & Prosthetic Services, LLC services provided not covered by the insurance policy as of the date listed below. If the insurance company denies coverage for products or services the undersigned will assume financial responsibility for the patient balance.

Medicare DMEPOS Supplier Standards

The signee acknowledges they have received a copy of the HCFA Medicare Supplier Standards as stipulated by Medicare.

Professional Orthotic & Prosthetic Services, LLC Company Policy

Professional Orthotic & Prosthetic Services, LLC will strive to protect your information and insure it is not used for other purposes not expressed or indicated in this form. If you wish to file a complaint about improper incidents please ask the owner, Brandon L. Smith CP, BOCO, MSOP for the proper paperwork and mailing address. If you choose to not participate in some of the already noted release please print them on the bottom of this page and initial beside them.

Authorization

I agree to pay in full all outstanding balances at the time work and/or services are completed. I recognize that my failure to pay my account in full within thirty days after work and/or services are completed may result in my balance being placed with a collection agency and possible listing with the credit bureau(s).

I further agree, in order for you to service my account or to collect any amounts I may owe, your organization's representatives, ancillary providers, HIPAA business associates, and the representatives of your debt collection agency, may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. Your organization's representatives, ancillary providers, HIPAA business associates, and the representatives of your debt collection agency may also contact me by sending text messages or emails, using any e-mail address I provide to you. Methods of contact may include using prerecorded/artificial voice messages and/or use of an automatic dialing device, as applicable. I have read this disclosure and agree that the Lender/Creditor, its ancillary providers, HIPAA business associates, and its debt collection agents may contact me as described above.

Patient's Signature (guardian/parent)

Date