PRO rthotics & OT, LLC

Notice & Consent to Treat

Patient Name: _____ Today's Date: _____

NOTICE OF PRIVACY PRACTICES

Acknowledgement of Receipt

By signing this form, you acknowledge that you have been offered a copy for review of PR Orthotics & OT, LLC's, Notice of Privacy Practices which is prominently displayed in the clinic and available on our website. This Notice of Privacy Practices provides information about how we may use and disclose your protected health information. Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice and if you have any questions about our Notice of Privacy Practices, please contact our Privacy Officer at (224)470-8550.

x_____ Date_____

Signature of Patient or Responsible Party

CONSENT TO TREAT & AUTHORIZATION TO RELEASE INFORMATION, ASSIGNMENT OF BENEFITS

I hereby authorize PR Orthotics & OT, LLC, (**PRO**) through its appropriate personnel, to perform the evaluation and treatment procedures that are deemed necessary by my physician and orthotist/therapist in the treatment of my condition. I further authorize PRO to furnish the appropriate agencies, for the purpose of billing, any information acquired during the course of my treatment and to send me notices and reminders of my appointments via text messaging. I am assigning my benefits to PRO, for the services in which I receive and authorize my insurance carrier to make payments to PRO on my behalf. PRO reserves the right to seek reimbursement from any and all of your insurers regardless of whether you provide us with their contact information, unless you instruct us to bill you directly. All records released require an administrative and copying fee paid to PRO before they are released, regardless of requestor. PRO is HIPAA compliant with regard to information sharing policies.

By signing this document, I acknowledge that I have read, understand and agree that the information contained in this document including insurance benefits and any information I have presented to verify my own identity including my state issued driver's license, state issued photo identification card or my passport, and if applicable any information used to verify the identity of a minor beneficiary is current, correct and complete to the best of my knowledge. I agree to the financial terms stated above.

I further understand and acknowledge that PRO may lease or license real estate, equipment or other personal property (collectively "Leased Property") from third parties to perform the evaluation and treatment procedures that are deemed necessary by my physician and therapist in the treatment of my condition. In consideration of being permitted to make use of and/or have access to the Leased Property, I do hereby, on behalf of myself, on behalf of any minor or other person for whom I have requested such evaluation and treatment procedures ("Minor"), on behalf of my heirs, successors and assigns, and on behalf of such Minor's heirs, successors and assigns release and forever discharge any and all direct or beneficial owners of the Leased Property and their respective successors, related entities, directors, officers, employees, and agents (collectively, "Releasees") from, and hereby waive and release, any and all claims, demands, actions, and causes of action whatsoever arising out of or in any way related to any loss, damage, or injury, including death, that may be sustained by me and/or such Minor in, on, upon, in connection with or while making use of the Lease Property, regardless of whether any such loss, damage, or injury is caused by the active or passive negligence of the Releasees or otherwise and regardless of whether any such liability arises in tort, contract, strict liability or otherwise, to the fullest extent allowed by law.

X_____ Date_____

Signature of Patient or Guardian