Streamline
ORTHOTICS

Patient Authorization and Consent

Patient Name (Last, First, MI) _____

Social Security # _____ Date of Birth _____

1. Consent for Treatment

I voluntarily give my permission to the health care providers of Streamline Orthotics, LLC to provide orthotic services to me. I understand by signing this form, I am authorizing them to treat me for as long as I seek care from Streamline Orthotics, LLC providers, or until I withdraw my consent in writing.

2. Release of Information and Authorization to Submit Claim

I hereby authorize Streamline Orthotics, LLC to release any medical information concerning my care, including copies of medical records and/or billing information pertaining to my medical care to individuals or representatives of agencies or organizations in connection with obtaining payment of services rendered to me. I certify that the information given by me in applying for payment is correct, and I authorize Streamline Orthotics, LLC to submit all necessary claims on my behalf. I acknowledge that this authorization has no expiration date.

3. Assignment of Insurance Benefits/Financial Responsibility

I hereby assign and authorize direct payments to Streamline Orthotics, LLC for all services rendered. I acknowledge that I am legally responsible for all charges in connection with the care and treatment provided by representatives of Streamline Orthotics, LLC, including all medical services, orthotic care, supplies, and equipment. I understand my insurance carrier may not approve or reimburse my medical services in full and that I am legally responsible for fees not paid in full, co-payments, and policy deductibles. I understand that my obligation to pay all charges is not affected by the fact that I have insurance benefits, and if my insurance company fails to pay all or any portion of these charges for any reason, I will be responsible for all sums due. In addition, I understand that all unpaid balances will incur a monthly service charge and any legal or collection costs involved.

4. Acknowledgement of receipt of Notice of Privacy Practices

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices for Streamline Orthotics, LLC.

I authorize Streamline Orthotics and Prosthetics to discuss my personal health information with the following persons, and understand that I can revoke this permission in writing at any time:

Name _____ Relationship _____

Name _____ Relationship _____

5. Acknowledgement of receipt of Medicare Supplier Standards:

I hereby acknowledge that I have received a copy of the Medicare Supplier Standards.

I agree to the above terms and conditions set forth by Streamline Orthotics, LLC. If I am the patient's authorized representative, I certify that I am duly authorized on behalf of the patient to execute such an agreement.

_____ _____

Signature of Patient Date

_____ _____

Signature of Parent/Guardian/Authorized Representative Relationship to patient