

(Patient Name)

(Pt. ID #)

**Assignment of Benefits / Authorization to Release Information**

I request that payment of authorized Medicare, Medicaid, or private insurance benefits be made to Orthotic & Prosthetic Lab, Inc. for any covered services furnished by Orthotic & Prosthetic Lab, Inc. I agree to pay to Orthotic & Prosthetic Lab, Inc. the deductible and/or coinsurance on my claim or any of my dependent(s). I further agree that should the amount be insufficient to cover the entire orthotic or prosthetic expense, I will be responsible for payment of the difference, and if the nature of the disability be such that it is not covered by the policy, I will be responsible to Orthotic & Prosthetic Lab, Inc. for payment of the entire bill.

I also understand that telephone inquiries to my insurance company **ARE NOT** a guarantee of coverage/benefits. We (Orthotic & Prosthetic Lab, Inc.) have attempted to estimate your balance due; however, after review by your insurance company, you may owe an additional amount.

I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents, Champus/TRICARE and its agents, or to any private insurance company any information needed to determine these benefits or the benefits payable for related services.

I further certify that the information provided by me is true, accurate and complete. If this is a private insurance claim, I further agree to be responsible for the full amount of the charges from the date of delivery if my private insurance company does not pay for the charges in a timely manner, or my physician or I fail to provide within (30) days the information necessary to submit the claim for payment.

**By checking this box and signing below, I acknowledge receiving a copy of Notice of Privacy Practices (NPP)**

**Patient or Representative Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**If Representative, please complete below.**

Printed Name: \_\_\_\_\_

Address: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Reason for Patient's Inability to Sign: \_\_\_\_\_

For Notice of Privacy practices only, describe the Personal Representative's authority to act on behalf of the patient:

\_\_\_\_\_

**Please list any individuals we may speak to or release information to:**

I authorize the following individuals, including myself to have access to information regarding self/patient.

\_\_\_\_\_  
Please print name relationship to patient

\_\_\_\_\_  
Please print name relationship to patient

Signature: \_\_\_\_\_ Date: \_\_\_\_\_