PATIENT CONSENT AND ACKNOWLEDGMENT FORM

Patient Name	MI	Last Name	
Insurance ID Number	Insurance Group Number	Date of Birth	Social Security Number

Notice of Privacy Practices for Protected Health Information

- I have been given a copy of *A New Step Prosthetics, LLC* Notice of Privacy Practices and understand these rights.
- I also understand that is my responsibility to notify the Privacy Officers in writing of any restrictions to my patient file. Forms are available through the Privacy Officer upon request.

Confidential Communication

- I hereby consent and grant permission for Practitioner's employed by *A New Step Prosthetics, LLC* to discuss my medical treatment for orthotics and/or prosthetics, with my referring physician, primary care physician, physical therapist, occupational therapist, hospital and/or rehabilitation staff, relating to my care and treatment.
- I also understand that it is my responsibility to notified the Privacy Officer in writing of any restrictions to my patient files. Forms are available through the Privacy Officer upon request.

Office Procedures

- I hereby give consent to *A New Step Prosthetics, LLC* to provide treatment and service(s) the assigned Provider may deem necessary.
- I understand that I am responsible for payment of charges ant that payment is due at time of service, or I hereby assign insurance benefits to be paid directly to *A New Step Prosthetics, LLC* for professional fees.
- I understand that I am responsible for charges not covered by my insurance policy.
- I understand that any amounts which are 90 days past due could be eligible for potential collections and turned over to a Collection Agency, unless prior arrangements have been made with the Business Administrator.
- Collection Agency fees are recognized to be my (the patient / responsible party(s)) responsibility.
- I understand that I am responsible for a fee of $35.00 for any returned check.

Release of Information and Authorization

- I hereby consent and permit a copy of this authorization and assignments to be used in place of this original signed document.
- I understand that this original will be placed in my file to be kept at the medical provider's office.
- I hereby authorize any practitioner examining and/or treating me, to release to any third party (such as an insurance company or governmental agency) any medical information and records concerning the diagnosis and treatment when requested for use in determining payment of claims.
- I understand that this is a Lifetime Release of Information unless I have placed restrictions in my patient file and have completed the necessary forms.
- I hereby consent and authorized *A New Step Prosthetics, LLC* to file medical claims for treatment, electronically or manually, to my insurance carrier(s) for service rendered to me.

Assignment of Benefits

- I request that payment of authorized Medicare benefits be made either to me or on my behalf to *A New Step Prosthetics, LLC* for any services furnished to me by that supplier.
- I authorize any holder of medical information about me to be released to the Center for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

______________________ ______________________ __________
Patient's Signature Patient's Printed Name Date

______________________ ______________________ __________
Representative's Signature Representative's Printed Name Date

Please describe your authority to act on the patient's behalf: ______________________________

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