

PATIENT CONSENT & ACKNOWLEDGEMENT FORM

Patient Name _____

Date of Birth _____

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I have been given a copy of South GA. Orthopedic Resources' Notice of Privacy Practices and understand these rights. I also understand that it is my responsibility to notify the Privacy Officer in writing of any restrictions to my patient file. Forms are available through the Privacy Officer upon request.

CONFIDENTIAL COMMUNICATIONS

I hereby consent and grant permission for Practitioner's employed by South GA. Orthopedic Resources 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 notify the Privacy Officer in writing of any restrictions to my patient file. Forms are available through the Privacy Officer upon request.

OFFICE PROCEDURES

I understand that I am responsible for payment of charges and that payment is due at the time of service, or I hereby assign insurance benefits to be paid directly to South GA. Orthopedic Resources 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 \$30 for any returned check.

RELEASE OF INFORMATION & 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 patient 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 authorize South GA. Orthopedic Resources to file medical claims for treatment, electronically or manually, to my insurance carrier(s) for services rendered to me.

ASSIGNMENT OF BENEFITS

I hereby consent and authorize payment to be paid directly to provider, South GA. Orthopedic Resources, for services rendered for any Orthotic and/or prosthetic services and treatment. Any services for which assignment is not accepted are acknowledged as being my full and complete financial responsibility.

CONSENT FOR TREATMENT

I hereby give consent to South GA. Orthopedic Resources to provide treatment and services to myself or minor child as ordered and deemed necessary by my medical provider.

I have read, understand and agree to all the above.

Patient's Signature:

Patient's Printed Name:

Date Signed

Representative's Signature:

Representative's Printed Name:

Date Signed