Restore Orthotics and Prosthetics Privacy Practices Acknowledgement, Consents, and Assignment of Benefits

Acknowledgment of Receipt of Notice of Privacy Practices and Company Policies

By signing below, I certify that Restore Orthotics and Prosthetics ("The Company") has made available to me a Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of Restore Orthotics and Prosthetics healthcare operations. The Notice of Privacy Practices also describes my rights and The Company's duties with respect to my protected health information. Restore Orthotics and Prosthetics reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, or asking for one at the time of my next appointment.

Consent for Contact

I, the undersigned, consent to be contacted by The Company by phone call, e-mail, US Postal Service or other means to follow-up on my care.

Use of Images

By signing below, I understand that Restore Orthotics and Prosthetics may use my likeness in a photograph or video as part of its marketing efforts including but not limited to publication in external communication and social media posts. I waive the right to inspect or approve the finished product wherein my likeness occurs. Additionally, I waive any right to royalties or other compensation related to the use of those images.

Consent to Provide Services and/or Products

I understand that by signing this agreement, I indicate my wish to purchase orthotic and/or prosthetic products or services, or both, from The Company. I understand that I am under the supervision and care of my attending physician. I understand that my physician has prescribed the orthosis/prosthesis noted as part of my treatment. I also understand that due to the nature of the products supplied by The Company that they cannot be returned.

Assignment of Benefits

I, the undersigned, hereby authorize The Company to request on my/our behalf and to collect directly all public and private insurance benefits due for products and/or services supplied to me by The Company. In the event payments for insurance benefits are made directly to any of the undersigned, the payee will endorse to The Company all checks for such payments.

Consent to Coordinate Care and Release of Medical Records

By signing below, I authorize all medical personnel to provide information to The Company concerning my medical history, as it may relate to my treatment. This includes collecting medical information from any physician, surgeon, medical facility and/or physical therapist seen by me. The Company will comply with all HIPAA rules and regulations.

Insurance Coverage

By signing below, I agree to inform The Company of any changes in my insurance coverage. If my insurance coverage changes or is terminated, I understand that I am responsible for all charges of services and devices delivered to me or in fabrication.

Patient Name Printed　　　　Patient Date of Birth

Patient/Guardian Signature　　　　Date

Guardian Printed Name　　　　Relationship to Patient

Originated: November 1, 2019