

PATIENT CONSENT & AUTHORIZATION FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I acknowledge receipt of notice of privacy practices and authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment of other healthcare providers/vendors involved in my treatment)
- Obtaining payment from third party payers
- The normal healthcare operations of your practice

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that I may contact you to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree with these restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use of disclosure that occurred prior to the day I revoked this consent is not affected.

In the event this practice changes hands, I also give you permission to transfer my records.

Print Patient Name: _____

Relationship to Patient: _____

Signature: **X** _____

Date: _____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but could not obtain because:

___ Individual refused to sign

___ Communication barrier prohibited

___ An emergency situation prevented obtaining acknowledgement

___ Other _____



**Benefits, Medical Information Release Authorization &
Acknowledgement of Financial Responsibility**

I request my insurance benefits, if any, be paid directly to the provider. I authorize the release of any information necessary to provide services or process claims. As the responsible party, I understand that I am personally responsible for the entire amount of my claim and that insurance benefits may be limited or non-existent. I agree to notify Westcoast Brace & Limb of any change in insurance coverage of status.

**Lifetime Medicare B Signature & Assignment of/and Authorization
to Pay Medical Expense Benefits**

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration, to its' intermediaries or carriers or billing agent of designated carrier, any information needed to this or a related claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the party who accepts assignment.

If policy specifically prohibits assignment, I request a check be made payable to BOTH SUBSCRIBER AND ABOVE COMPANY and sent directly to the COMPANY.

NOTE: Payment by an obligor to a person other than the assignee after notification of assignment may result in liability to the obligor to repay the amount paid.

Secondary Insurance Authorization & Assignment

I authorize payment of medical benefits to the party who accepts assignment.

Responsibility

I understand that the entire amount of the fees for your services and/or Orthotic and Prosthetic devices is my personal responsibility even though this may or may not be covered by insurance. If you bill the insurance company directly, I understand that I am to pay my portion of the bill when your service is rendered. I further agree to personally pay within thirty (30) days any portion of the bill that is outstanding.

In the event this bill is turned over to a third party for collection, I agree to pay all reasonable collection fees including attorney and Court cost, plus 1.5 percent monthly charge on the outstanding balance.

Patient Signature: X _____

Date: _____

North Tampa	West Tampa	Brandon	Palm Harbor	St. Petersburg
813-985-5000	813-354-0100	813-684-5525	727-785-0100	727-323-9500
813-985-4499 Fax	813-348-0629 Fax	813-653-3730 Fax	727-785-7773 Fax	727-327-7626 Fax