

Wilmington Orthotics & Prosthetics, Inc.
3909 Oleander Drive, Ste E
Wilmington, NC 28402
910-395-5775

- 1. CONSENT FOR TREATMENT:** I, the undersigned, hereby consent to treatment under the recommendations and instructions of the physician/therapist.
- 2. RELEASE OF MEDICAL RECORD INFORMATION:** I authorize any holder of medical or other information about me to release such information as may be necessary for the completion of my insurance claims to Wilmington Orthotics and Prosthetics, Inc. A photocopy of this authorization is to be considered valid.
- 3. ASSIGNMENT OF INSURANCE BENEFITS:** I hereby authorize direct payment to Wilmington Orthotics and Prosthetics, Inc. for my insurance benefits herein specified and otherwise payable to me. I also hereby authorize automated claims to be submitted electronically to Medicare on my behalf.
- 4. MEDICARE AUTHORIZATION:** I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

I also authorize the Social Security Administration Department to furnish any benefit information regarding my Medicare eligibility to Wilmington Orthotics and Prosthetics, Inc.

- 5. WAIVER OF LIABILITY OR GUARANTEE OF ACCOUNT:** I understand I will be financially and legally responsible for charges not covered by this assignment. The undersigned further agrees to pay all costs of collection of any such balance, including responsible attorney's fees.

FOR MEDICARE RECIPIENTS ONLY: Medicare will only pay for services that are determined to be "reasonable and necessary" under Section 1862 (a) (1) of the Medicare Law.

We believe that Medicare is likely to deny payment for the following services: _____

for the following reasons: _____

I understand that it is my right as a patient to request an itemized bill at any time. My signature acknowledges receipt of:

Summary of Notice of Privacy Practices for Wilmington Orthotics & Prosthetics, Inc.
HCFA Medicare DMEPOS Supplier Standards
Acknowledgement of Receipt of Notice of Privacy Practices (**Other side**)

Name of Patient or Personal Representative

Description of Personal Representative's Authority

Signature of patient or legal representative

Date