Release & Consent Form

Assignment of Benefits

The customer requests that payment of authorized insurance benefits be made on the customer's behalf to Miller Prosthetics & Orthotics, LLC for any services furnished. The customer understands that the signature requests the payment by the insurance carrier be made directly to Miller Prosthetics & Orthotics, LLC.

Medical Information Release Authorization

The customer authorizes any holder of medical information about the customer to be released to Miller Prosthetics & Orthotics, LLC or its agents any information needed to determine benefits or the benefits payable for related services. The customer understands that their signature authorizes release of medical information necessary to pay the claim.

Financial Responsibility Consent

The undersigned agrees to assume financial responsibility for any claim or portion of claim thereof, due Miller Prosthetics & Orthotics, LLC for services provided, not covered by the insurance policy as of the date listed below. If the insurance company denies coverage for a product, the undersigned will assume financial responsibility for its payment. The undersigned acknowledges the responsibility for any payment not received from the insurance carrier within thirty (3o) days from the date of service. The undersigned also acknowledges that payments ofthe copay and deductible are due at the time of delivery.

Video and Photograph Consent

The undersigned agrees consent to being photographed and/or videotaped for use in patient records and clinical evaluations. The undersigned understands that these images will only be used for clinical and educational purposes.

Please sign below, or by electronic signature, stating that you have read, understand and acknowledged the above information regarding your consent for the use and disclosure of protected health information.

_____ _____

Patient/Guardian Signature Date

_____

Patient Name

Signatures are digitally captured in OPIE Facility Documents Management