

AMERICAN LIMB & ORTHOPEDIC COMPANY OF VALPARAISO

RELEASE/CONSENT FORM

***THIS RELEASE/CONSENT FORM MUST BE COMPLETED IN ORDER FOR AMERICAN LIMB & ORTHOPEDIC COMPANY OF VALPARAISO TO BILL YOUR INSURANCE COMPANY AND FOR YOU TO UNDERSTAND YOUR FINANCIAL RESPONSIBILITY.*

PLEASE READ CAREFULLY AND INITIAL EACH ONE AND SIGN BELOW:

_____ 1. The patient requests that payment of authorized insurance benefits be made, on the patient's behalf, to the American Limb & Orthopedic Company of Valparaiso for the orthotic or prosthetic services rendered. The patient understands that their signature (below) authorizes payment by the insurance carrier to be made directly to the American Limb & Orthopedic Company of Valparaiso.

_____ 2. The patient authorizes any holder of medical information, regarding the patient that is needed for clinical purposes or for the determination of benefits, or benefits payable, for related services are released to the American Limb & Orthopedic Company of Valparaiso. The patient understands that their signature (below) authorizes the release of medical information.

_____ 3. American Limb & Orthopedic Company of Valparaiso is not a financial lending institution, therefore payment arrangements can not be made with us. We accept major credit cards, cash, check, and money orders. Full payment is due on the date of service. For custom items, we require a down payment of half the amount that is due before work will begin on any item.

_____ 4. The patient agrees to assume financial responsibility for any claim not covered by the insurance policy or portion of claim thereof such as a non covered item, deductible, or co-pay due to the American Limb & Orthopedic Company of Valparaiso for services rendered. If the insurance company denies coverage for a product, the patient will assume financial responsibility for this payment. The patient acknowledges the responsibility for any payment not received from the insurance carrier within sixty (60) days from the date of service. Returned checks and balances older than 60 days may be subject to additional collection charges.

_____ 5. It is the responsibility of the patient to notify American Limb & Orthopedic Company of Valparaiso of any changes in insurance coverage, employment, functional status, or personal information such as address and telephone contact information.

(Print) PATIENTS NAME: _____ DATE: _____

PARENT OR AUTHORIZED NAME: _____

RELATIONSHIP TO PATIENT: _____

X

SIGNATURE OF PATIENT, PARENT, GUARDIAN, OR AUTHORIZED