Integrity
Prosthetics • Orthotics
Research • Education

Acknowledgment of Receipt of Notice of Privacy Practices and Consent for the use and Disclosure of Protected Health Information

By signing below, you consent to the use and disclosure of your protected health information by Integrity P&O, our staff, and our business associates for treatment, payment and health care operations purposes. This protected health information includes personal and medical information, clinical photographs, treatment history, and all information pertaining to your treatment at this facility. For a more detailed description of our uses and disclosures of protected health information, please review our Notice of Information Practices ("Notice"), which you acknowledge receiving on this date. You have the right to review our Notice prior to signing this consent. The terms of this Notice may change. If the terms do change, you may obtain a revised Notice by simply contacting us at (863)937-9200 and requesting a revised Notice. You have the right to request that we restrict our uses or disclosures of your protected health information that we are otherwise permitted to make for treatment, payment and health care operations, although we are not required to agree to these restrictions. However, if we agree to further restrictions, they are binding on us. Finally, you have the right to revoke the consent in writing, except to the extent that we have taken action in reliance on it.

AGREED and ACKNOWLEDGED:

_____ _____

Printed Name of Patient Date

_____

Signature of Patients

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Release and Consent Form

Assignment of benefits:

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

Medical Information Release Authorization:

The customer authorizes any holder of Medical information about the customer to be released to Integrity Prosthetics & Orthotics or its agents any information needed to determine benefits or the benefits payable for related services. The customer understands that the below 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 Integrity Prosthetics & Orthotics for services provided, and 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 also acknowledges that payments of the co pay and deductible are due at the time of delivery.

Consent to Treat:

Customer agrees to be treated by Integrity Prosthetics & Orthotics.

Medicare:

The customer acknowledges the receipt of Medicare supplier standards.

Video and Photograph Consent:

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

I have read and understand the above.

_____ _____

Printed Name of Patient Date

_____

Signature of Patient