Ontario Prosthetic Systems

Patient Name:_____Date_____

Assignment of Benefits/Authorization to Release Information/HIPPA Acknowledgement

I request that payment of authorized Medicare, MediCal, or private insurance benefits be made to Ontario Prosthetic Systems for any covered services furnished by Ontario Prosthetic Services. I agree to pay Ontario Prosthetic Systems the deductible and/or coinsurance on my claim.

I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

I understand that I am responsible for all fees not covered by Insurance, Medicare, Medical Assistance or other Governmental Agencies, or Worker's Compensation except where prohibited by law.

I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents, Champus/TRICARE and its agents, or to any private insurance company any information needed to determine these benefits or the benefits payable for related services.

I further certify that the information provided by me is true, accurate and complete. I understand and agree that I am responsible for the following expenses: any service my insurance plan deems "non-covered", all coinsurance and/or co-payment amounts, all deductibles, any amount that exceeds benefit limits under my insurance plan and any amount my insurance plan deems not covered because I was not insured on the date of service.

I acknowledge having received 1) a copy of Ontario Prosthetic Systems Notice of Privacy Practices (NPP), 2) Medicare Supplier Standards, 3) Bill of Rights, 4) Warranty & Patient Responsibilities and 5) Ontario Prosthetic Systems Financial Policy.

Patient or Responsible Party Signature Date

_____**Date** _____

If Responsible Party, please complete below:

Printed Name_____

Address_____

Relationship to Patient: _____

Reason for Patient's Inability to Sign:_____

For Notice of Privacy Practices only, describe the Responsible Party's authority to act on behalf of the patient:_____