Assignment of Benefits Consent Form

I request that payment of my authorized Medicare, MEDIGAP, and/or my private insurance benefits be made to Boland Prosthetic & Orthotic Center on my behalf for any services furnished to me. I authorize any holder of medical information to release to my insurance company or companies and their agents any information needed to determine these benefits or the benefits payable for related services. I hereby assign to Boland Prosthetic & Orthotic Center all payment for medical services rendered to me or my dependents. I understand that I am responsible for any amount not covered by insurance, as well as, any denial because of ineligibility on date of service.

I understand that I will be informed if it is known that the device(s) may not be covered by my insurance plan. Benefits verified with your insurance companies are not a guarantee of payment and if your claim is denied you agree to be fully responsible for payment that your insurance company determines to be patient responsibility. Any balance on your current year's insurance deductible(s) will be due at the time of service. We may also request that you pay your coinsurance amount if applicable. It is the patient's responsibility to understand the deductibles and coverage of their health insurance plan(s).

Patient Photograph & Video Consent Form

As a documentation procedure, I understand that Boland Prosthetic & Orthotic Center will photograph me (either still or recorded video) and/or my orthosis/prosthesis for possible submittal to my insurance company as documentation of receipt, fabrication, or to support medical need for device(s). I consent for my photo and/or video to be used for payment/authorization with my current Medicare, MEDIGAP, or private insurance company and that I will be given a written request for consent if Boland Prosthetic & Orthotic Center desires to use my photo in any other way.