Patient Signature and Release Form

I acknowledge that I read, understand and agree to the terms of the following forms provided by Falk Prosthetics & Orthotics, Inc. (hereinafter "Falk P&O"):

-Notice of Privacy Practices
-Falk Prosthetics & Orthotics, Inc. Financial Policy
-Falk Prosthetics & Orthotics, Inc. Patient Information Form

Previous Brace History

Medicare, as well as other insurance companies, has specific guidelines with regard to supplying multiple orthotic/prosthetic devices to one patient. Sometimes, the second same or similar device provided within a specific period of time, regardless of who supplied these devices, will be denied for payment as it may be deemed not medically necessary. Due to these guidelines, it is critically important that you make us aware of your orthotic/prosthetic device history.

Please take a moment to consider your orthotic/prosthetic device history. This information is important for us to help you make informed decisions about any devices supplied to you now and what your financial responsibility may be.

Have you received an orthotic or prosthetic device within the previous five years?

_____ yes _____ no

If you answered yes, please supply us with the approximate date you received the device and describe the item received.

Date Item Received

I have read the above information and I understand its content. I further understand that if I have received previous orthotic or prosthetic devices, my insurance company may deny payment and I can be held financially responsible for the items received.

CONSENT FOR TREATMENT, AUTHORIZATION TO RELEASE INFORMATION INCLUDING PHOTOGRAPH AND ASSIGNMENT OF PAYMENT OF INSURANCE BENEFITS TO FALK P&O

Medicare DMEPOS Supplier Standards - The products and/or services provided to you by Falk Prosthetics & Orthotics, Inc. are subject to the supplier standards contained in the Federal regulations shown at 42 Code of Federal Regulations Section 424.57©. These standards concern business professional and operational matters (e.g. honoring warranties and hours of operation). The full text of these standards can be obtained at http://ecfr.gpoaccess.gov. Upon request we will furnish you a written copy of the standards.

I acknowledge and I authorize Falk P&O to deliver, teach, administer, or perform, as necessary, the product and treatment prescribed by my Health Care Provider. I authorize the use of the information provided on the **Falk Prosthetics & Orthotics, Inc. Patient Information Form** or Hospital/Facility Face Sheet for hospitalized patients and I allow the release of my medical information to all my insurance companies. I hereby acknowledge that I have received a copy of the **Notice of Privacy Practices for Falk P&O**. In addition, I agree that if Falk P&O or my Health Care Provider takes a photograph of me in connection with a product that I have received from them, I give Falk P&O permission to use this photograph in their attempt to obtain payment for the product. **I authorize Falk P&O to submit a claim, for a product I have received from them, to my insurer on my behalf, and I assign the benefits payable by my insurer for such product to Falk P&O. I understand and agree that I am personally and fully responsible for, and I agree to pay to Falk P&O, any portion of the amount due for such product not paid by my insurer, whether resulting from deductibles, co-pays, or otherwise.**

Patient's Signature Date

Signature of Patient Representative Relationship of Patient Representative to Patient

Falk Prosthetics & Orthotics, Inc. Financial Policy

PLEASE READ CAREFULLY

Payment For Services Rendered

Payment is due at the time of service. We accept cash, checks, Visa, American Express and MasterCard. We offer an extended payment plan with prior credit approval and arrangements. <u>If you consult with the practitioner and opt to not receive a device, there is a $50.00 consultation fee. This fee will not be billed to your insurance company and is due at the end of your consultation visit.</u>

Regarding Insurance

Falk P & O agrees to bill most insurance carriers, if all necessary information is provided. Should your insurance not cover the services provided, the balance is your responsibility. If your insurance company has not paid your account within 45 days, the balance will be automatically transferred to your responsibility. A statement will be mailed to you and payment is expected upon receipt.

Your insurance policy is a contract between you and your insurance company. Coverage cannot be guaranteed. Estimates that we provide may be NON-COVERED services under the Medicare program and/or other medical insurance. In this instance, a statement will be mailed to you and payment is expected upon receipt.
If you receive payment directly from your insurance carrier for services rendered to you by Falk Prosthetics & Orthotics, Inc. you agree to forward that payment to us within five days of your receipt of the payment.

In the event that you are billed by Falk Prosthetics & Orthotics, Inc. for services rendered and payment is not made, your account will be forwarded to our collection firm for further action. You will then be held responsible for all collection fees incurred including, but not limited to, lawsuit filing fees, service of process fees, attorney's fees, and all other legal fees and costs as a result of this action in addition to your outstanding balance with Falk Prosthetics & Orthotics, Inc.

Usual and Customary Rates

It is our policy to charge our patients and their insurers in a fair and consistent manner. Our fees are set at usual and customary rates for this area.

Minor Patients

The adult accompanying a minor is responsible for payment. If the minor is unaccompanied by an adult, he/she must present payment at the time services are rendered or prior arrangements must be made.

Return Policy

Due to the intimate nature and/or custom fit of all devices provided by Falk Prosthetics & Orthotics, Inc., all items provided are non-returnable and non-refundable.

Returned Checks

Should you choose to make payment to Falk Prosthetics & Orthotics, Inc. by check and it is returned, a fee of $25.00 will be charged to your account.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Effective Date of this notice: April 14th, 2003

Falk Prosthetics & Orthotics, Inc.

5180 W. Atlantic Ave. Ste. 116 Delray Beach, FL 33484

WHO WILL FOLLOW THIS NOTICE

This notice describes the information privacy practices followed by our employees, staff and other office personnel. The practices described in this notice will also be followed by health care providers you consult with by telephone (when your regular health care provider from our office is not available) who provide "call coverage" for your health care provider.

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about your health, health status, and the health care and services you receive at this office. We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment

We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health.

For example, your doctor may be treating you for a heart condition and may need to know if you have other health problems that could complicate your treatment. The doctor may use your medical history to decide what treatment is best for you. The doctor may also tell another doctor about your condition so that doctor can help determine the most appropriate care for you.

Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning in prescription's to your pharmacy, scheduling lab work and ordering x rays. Family members and other health care providers may be part of your medical care outside this office and may require information about you that we have.

We have an open waiting room. We will attempt to keep your personal health information (PHI) to the minimum.

For Payment

we may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment.

For Health Care Operations

We may use and disclose health information about you in order to run the office and make sure that you and our other patients receive quality care. For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

Appointment Reminders

We may contact you as a reminder that you have an appointment for treatment or medical care at the office.

Treatment alternatives

We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health Related Products and Services

We may tell your about health related products or services that may be of interest to you.

Please notify us if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communications about treatment alternatives or health related products and services. If you advise us in writing (at the address listed at the top of this Notice) that you do not wish to receive such communications, we will not use or disclose your information for these purposes.

You may revoke your *Consent* at any time by giving us written notice. Your revocation will be effective when we receive it, but it will not apply to any uses and disclosures which occurred before that time.

If you do revoke your *Consent*, we will not be permitted to use or disclose information for purposes of treatment, payment or health care operations, and we may therefore choose to discontinue providing you with health care treatment and services.

SPECIAL SITUATIONS

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

To Avert a Serious Threat to Health or Safety

We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Required by Law

We will disclose health information about you when required to do so by federal, state or local law.

Research

We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.

Organ and Tissue Donation

If you are an organ donor, we may release health information to organizations that handle organ procurement or organ eye or tissue transplantation or to an organ donation and transplantation.

Military, Veterans, National Security and Intelligence

If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. Few may also release information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation

We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work related injuries or illness.

Public Health Risks

We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

Health Oversight Activities

We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes

If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

Law Enforcement
We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process.
Coroners, Medical Examiners and Funeral Directors
We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine cause of death.
Information Not Personally Identifiable
We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.
Family and Friends
We may use or disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed.
In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care. For example, we may inform the person who accompanied you to the emergency room that you suffered a heart attack and provide updates on your progress and prognosis. We may also use our professional judgment and experience to make reasonable inferences that is in your best interest to allow another person to act on your behalf to pick up, for example, filled prescriptions, medical supplies or X-rays.
OTHER USES AND DICLSOSURES OF HEALTH INFORMATION
We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *Authorization*. We must obtain your *Authorization* separate from any *Consent* we may have obtained from you. If you give us *Authorization* to use or disclose health information about you, you may revoke that *Authorization*, in writing, at any time. If you revoke your *Authorization*, we will no longer use or disclose information about you for the reasons covered by your written *Authorization*, but we cannot take back any uses or disclosures already made with your permission.
If we have HIV or substance abuse information about you, we cannot release that information without a special signed, written authorization (different than the *Authorization* and *Consent* mentioned above) from you. In order to disclose these types of records for purposes of treatment, payment or health care operations, we will have to have both your signed *Consent* and a special written *Authorization* that complies with the law governing HIV or substance abuse records.
YOUR RIGHTS REGARDING HEALTH INOFRMATION ABOUT YOU
You have the following rights regarding health information we maintain about you:
Right to Inspect and Copy
You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to our privacy official in order to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.
Right to Amend
If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office.
To request an amendment, complete and submit a Medical Record Amendment/Correction Form to our privacy official. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

a) We did not create, unless the person or entity that created the information is no longer available to make the amendment.
b) Is not part of the health information that we keep.
c) You would not be permitted to inspect and copy.
d) Is accurate and complete.

Right to an Accounting of Disclosures
You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment and health care operations. To obtain this list, you must submit your request in writing to our privacy official. It must state a time period, which may not be longer than six years and my not include dates before April 14th, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). We may charge you for the costs of providing the list. We will notify you for the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.
Right to Request Restrictions
You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.
We are Not Required to Agree to Your Request
If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.
To request restrictions, you may complete and submit a *Request For Restricting Uses and Disclosures and Confidential Communications* to our privacy official. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
Right to Request Confidential Communications
You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.
To request confidential communications, you may complete and submit the *Requests For Restricting Uses and Disclosures and Confidential Communications* to our privacy official. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
Right to a Paper Copy of This Notice
You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain such a copy, contact our privacy official.
CHANGES TO THIS NOTICE
We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date in the top right hand corner. You are entitled to a copy of this notice currently in effect.
COMPLAINTS
If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office contact our privacy official. You will not be penalized for filing a complaint.