



Assignment of Benefits Form

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical, diagnostic and surgical benefits, to include major medical benefits to which I am entitled to Ortheco Prosthetics. I hereby authorize and direct my insurance carrier(s), including Medicare, Medicaid, Workman's Compensation, Veteran's Administration, private insurance and any other health/medical plan to issue payment directly to Ortheco Prosthetics for medical services and devices rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Ortheco Prosthetics to (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

I have requested medical services from Ortheco Prosthetics on behalf of myself and/or my dependents and understand by making this request I become fully financially responsible for any and all charges incurred in the course of the authorized treatment.

I further understand that all fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Print Name of Patient/Responsible Party

Patient/Responsible Party Signature

Date

Parent/Guardian Signature Relationship

Witness Witness Signature

Date