GULF COAST PROSTHETICS
GULFCOASTPROSTHETICS.COM
(281) 292-2255

_____

(Patient's Printed Name)

PATIENT ACKNOWLEDGEMENT

Assignment of Benefits/Authorization to Release Information: I request that payment of authorized Medicare, Medicaid, or private insurance benefits be made to Gulf Coast Prosthetics for any covered services furnished by Gulf Coast Prosthetics. I agree to pay Gulf Coast Prosthetics the deductible and/or coinsurance on my claim. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents, or to any private insurance company any information needed to determine these benefits or the benefits payable for related services.

Financial Policy: 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, and 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. The date of service is deemed as the final day in which you receive your device.

Consent to Treat: I hereby authorize Gulf Coast Prosthetics to perform evaluations and/or treatment services and hereby grant and/or give consent to Gulf Coast Prosthetics as follows: I give the professionals working with me or my child, consent to contact other professionals outside of Gulf Coast Prosthetics regarding me or my child's condition while undergoing evaluation, and treatment by Gulf Coast Prosthetics.

Consent to Contact: I hereby authorize Gulf Coast Prosthetics to contact me in relation to my personal patient information and to share other Gulf Coast Prosthetics information that might be pertinent to me.

CMS Medicare Supplier Standards: I acknowledge having received and/or reviewed the Medicare Supplier Standards.

Notice of Privacy Practices (HIPAA): I acknowledge having received and/or reviewed the Notice of Privacy Practices.

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I further certify that the information provided by me is true, accurate and complete.

_____ _____

Patient or Responsible Party Signature **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:_____