COMPREHENSIVE
PROSTHETICS & ORTHOTICS

PATIENT CONSENT & ACKNOWLEDGEMENT

PATIENT NAME	ACCOUNT NUMBER

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I have been given a copy of **CPO Services, Inc.** Notice of Privacy Practices and understand these rights. I also understand that it is my responsibility to notify the Privacy Officer in writing of any restrictions to my patient file. Forms are available through the Privacy Officer upon request.

CONFIDENTIAL COMMUNICATIONS

I hereby consent and grant permission to CPO Services, Inc. and/or its affiliates to discuss my medical treatment for orthotics and/or prosthetics, with all involved medical providers relating to my care and treatment, including but not limited to my referring physician, primary care physician, physical therapist, occupational therapist and/or hospital staff. As a component of medical documentation, I agree to being photographed and/or videotaped for use in supporting documentation of patient records and clinical evaluations. I understand that these images will only be used for purposes as outlined in the Notice of Privacy Practices unless I give specific written consent to use otherwise. Additionally, with this consent, CPO Services, Inc. and its affiliates may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminders, insurance items, and/or send mail to my address as designated on my registration forms.

OFFICE PROCEDURES

I hereby authorize CPO Services, Inc. and/or its affiliates to provide treatment and service(s) the assigned Provider may deem necessary. I understand that I am responsible for payment of charges and that payment is due at the time of service. I understand that I am responsible for charges not covered by my insurance policy. I understand that any amounts which are 90 days past due could be eligible for potential collections and turned over to a Collection Agency, unless prior arrangements have been made with the Business Administrator. Collection Agency fees are recognized to be my (*the patient/responsible party(s)*) responsibility. I understand that I am responsible for fees related to returned checks.

RELEASE OF INFORMATION & AUTHORIZATION

I hereby consent and permit a copy of this authorization and assignment to be used in place of this original signed document. I understand that a copy of this document will be maintained in my patient file. I hereby consent and authorize CPO Services, Inc. and/or its affiliates to file medical claims for treatment, electronically or manually, to my insurance carrier(s) for services rendered to me and to release to any third party (*such as an insurance company or governmental agency*) any medical information and records concerning the diagnosis and treatment when requested for use in determining payment of claims. I understand that this is a Lifetime Release of Information unless I have placed restrictions in my patient file and have completed the necessary forms.

ASSIGNMENT OF BENEFITS

I hereby consent and authorize payment to be made directly to CPO Services, Inc. and/or its affiliates, for supplies and services rendered on all orthotic and/or prosthetic services and treatment provided. Any services for which assignment is not accepted are acknowledged as being my full and complete financial responsibility.

I have read, understand and agree to the above information.

Signature _____ Date _____

Representative's Signature _____ Date _____

Representative's Printed Name _____

Representative's Printed Name _____

** Affiliates include MD Orthotics and Prosthetics Laboratory, Inc. and DJ Peters Orthopedics, Ltd*