

Patient Name: _____ DOB: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Release To:

Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Medical Records should include:

- Physical Exam(s)
- Treatment and/or Assessment Note(s)
- Billing Notes
- Other: _____

I hereby request and authorize Fourroux Prosthetics, Inc. to release my medical records and related information to the above mentioned for the purpose of providing medical care and treatment to me.

My restrictions on this authorization are limited to the information indicated above.

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment, or eligibility for benefits may be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing. No revocation is given if authorization has already been relied upon to obtain services.
4. If the requestor or receiver is not a health plan or provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
5. The purpose for the release of these records is healthcare related.

This authorization is valid for five (5) years from today's date, unless revoked in writing beforehand.

Insurance Authorization / Release Form

Release To: Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

I authorize the use of this form on all my insurance submissions.

Fourroux Prosthetics, Inc. shall act as my agent in helping me obtain payment from my insurance companies including obtaining medical records from other physicians and/or medical providers which may be requested by my insurance companies.

I understand that my signature requests that payment be made and authorizes release of medical information to my insurance companies, necessary to process the claim, with payment to be made to **Fourroux Prosthetics, Inc.**

Office Financial Policy/Equipment Warranty

Office Financial Policy

The staff at Fourroux Prosthetics, Inc. understands that you have choices in providers, and we greatly appreciate your trust in selecting our company. Please be aware that our products and services are billed under the major medical portion of your insurance; therefore, deductibles, co-insurance, and sales tax do apply depending on your coverage. Medicare pays 80% of the allowable charges after your annual deductible has been met; however, not all items are covered. Other insurance coverage varies, and we will check your coverage and let you know what to expect. The following applies to our policy:

1. Copy of photo identification and insurance cards are requested at time of visit.
2. Payment of co-insurance and/or deductible is due at time of delivery.
3. Payment arrangements will be made at time of service rendered.
4. Any balance due after payment by insurance company must be made within 30 days unless you request other arrangements prior to the end of the initial 30-day period. Any unpaid balances may be turned over to collections.
5. If you do not have insurance, total payment is due at the time of service unless other arrangements have been made and approved by management.
6. This office accepts credit cards.
7. This office accepts checks with proper identification. A charge of \$25 will be assessed for any returned checks.
8. We will file most insurance claims for you. Some insurance companies with whom we are not a network provider with will require you to file any claims.
9. Please feel free to call (256) 534-8672 or 1-888-810-6220 with any account questions

Equipment Warranty

Fourroux Prosthetics, Inc. will notify all patients of the warranty coverage, and we will honor all warranties under applicable law. In addition, an owner's manual with warranty information will be provided to patients for all products where a manual is available.

Fourroux Prosthetics, Inc. will replace, repair, or adjust devices free of charge for **ninety (90)** days from date of delivery if the item is found to be deficient in material or workmanship. Beyond the ninety (90) day warranty period, adjustments and repairs will be made at the current rate for labor.

Fourroux Prosthetics, Inc. will accept returns on over-the-counter soft good items not covered under manufacturer warranty, only if they are in a like new condition, and can be resold. Items should be in their original packaging and must be returned within **five (5)** business days of purchase. All returns for refund will be at the discretion of management Any and all restocking fees assessed by the manufacturer will be the sole responsibility of the patient.

Photograph / Social Media

Consent & Release

- I **consent** to the participation of interviews, use of quotes, photographs and/or videos by Fourroux Prosthetics, Inc. Fourroux Prosthetics, Inc. has the right to edit, use, and reuse images and/or videos in, but not limited to, print publications, online publications, presentations, websites, and social media. I understand that no royalty, fee, or other compensation shall become payable to me by reason of such use.
- I **do not consent** to the participation of interviews, use of quotes, photographs and/or videos by Fourroux Prosthetics, Inc

Acknowledgement / Consent

I acknowledge I have been provided a copy of Fourroux Prosthetics' Notice of Privacy Practice.

I consent to the release and use of my protected health information as HIPAA permits.

Print Name

Patient / Authorized Signature*

*Relationship to Patient

Date