WINKLEY ORTHOTICS & PROSTHETICS

Patient Consent for Purposes of Treatment, Payment and Healthcare Operations

PLEASE PRINT TODAY'S DATE _____

PATIENT INFORMATION				
PATIENTS LAST NAME		FIRST NAME		M.I.
STREET ADDRESS APT#		CITY	STATE ZIP CODE	
HOME PHONE	EMPLOYER	WORK PHONE	DIAGNOSIS	
BIRTH DATE	SOCIAL SECURITY NUMBER	SEX	DOCTOR'S NAME	
EMERGENCY NAME		RELATIONSHIP	PHONE	
INSURANCE SUBSCRIBER NAME		RELATIONSHIP TO PATIENT	SUBSCRIBER DOB	

To our patients: The law requires that we inform you of your rights to privacy and responsibilities as a patient of Winkley Orthotics and Prosthetics (Winkley). Below you are asked to read each section and place a check mark next to those to indicate your approval. If you have a complaint or concern regarding this form or care at Winkley, please feel free to ask for assistance or to speak to Alexander P. Gruman President, The Winkley Company. After reading and indicating your agreement with the areas below that you approve of please sign and date the form.

Protected Health Care Information :

____ I Release my Protected Health Information for Treatment, Billing and Health Care Operations. Protected Health information is any written or oral health information, including your demographic data that can be used to identify you.

____ I have been given a copy of Winkley's privacy notice.

Insurance / Medicare / Medicaid Assignment of Benefits:

____ I request payment of authorized benefits be made to and Assign the benefits for services to Winkley on my behalf for any services furnished to me by Winkley. I understand that I agree to pay for all charges not covered by any third party.

I understand that title for any products provided to me by Winkley does not transfer to me until payment for the services has been made in full.

Medicare Standards:

____ I have been given a copy of the Medicare Standards.

I understand that diagnosis or treatment of me by Winkley may be conditioned upon my consent as evidenced by my signature on this document.

_____ _____

Print Name of Patient or Personal Representative Signature of Patient or Personal Representative

_____ _____

Print Personal Representatives Name Date

_____ **E-mail Address**_____

Description of Personal Representative's Authority

Reason Patient unable to sign: _____

I understand that adjustments to the appliance will be made at no charge for 90 days following delivery and that any defective component parts will be replaced as allowed by the original manufacturer's warranty. No other guarantees are expressed or implied.