Limbionics

Consent for Treatment/Release of Medical Information/Assignment of Benefits/Acknowledgement of Receipt of Notice of Privacy Practices

Consent for Treatment: I, the undersigned, hereby consent to the treatment under the recommendations and instructions of the physician and/or therapist. I realize that I am financially responsible for charges incurred once treatment has been performed or products have been special ordered for my use.

Release of Medical Records: I authorize any holder of medical or other information about me to release such information as may be necessary for the completion of my insurance claims to Limbionics . A photocopy of this authorization form is to be considered valid. I also consent to the release of my medical and private health information by Limbionics for use as described in the Notice of Privacy Practices.

Notice of Privacy Practices: My signature below acknowledges receipt of the Notice of Privacy Practices, which describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of Limbionics health care operations. The Notice of Privacy Practices also describes my rights and Limbionics duties with respect to my protected health information. The Notice of Privacy Practices is posted in the Patient Waiting Room. Limbionics reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised copy by calling the office and requesting a revised copy be sent in the mail.

Assignment of Insurance Benefits: I hereby authorize direct payment to Limbionics for my insurance benefits herein specified and otherwise payable to me. I also hereby authorize automated claims to be submitted electronically to Medicare on my behalf.

It is necessary for the patient or representative to give complete and accurate insurance information. If the information is incomplete or incorrect, we will not be able to appropriately bill the insurance company and the responsibility for payment than becomes that of the patient.

Insurance payments are usually received within 30-60 days from the time of billing. If a patient's insurance has not made payment to our office within 90 days, we may request the patient to pay the balance due, and then seek reimbursement from the insurance company when and if it pays.

Our office does not guarantee that the patient's insurance company will pay for services rendered. We will perform our routine insurance billing procedures upon verification of coverage. However, if for some reason the patient's insurance claim is denied, the patient is then considered to be responsible for charges not covered by this assignment. The undersigned further agrees to pay all costs of collection of any such balance including attorney's fees.

For Medicare Recipient's Only: Medicare Authorization-I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its Intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I also authorize Social Security Administrative Dept. to furnish any benefits information regarding my Medicare eligibility to Limbionics. *Medicare will only pay for services that are determined to be "reasonable and necessary" under section 1862(a)(i) of the Medicare law.*

*****I have read and acknowledged the information listed above** ______________________________

Signature