Bulow Orthotic & Prosthetic Solutions
Privacy Practices Acknowledgement, Consents and Assignment of Benefits

Acknowledgement of Receipt of Notice of Privacy Practices and Company Policies

By signing below, I certify that Bulow Orthotic & Prosthetic Solutions, its parent company & its subsidiaries ("The Company") has made available to me a Notice of Privacy Practices. The Notice of Privacy Practices 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 Bulow Orthotic & Prosthetic Solutions healthcare operations. The Notice of Privacy Practices also describes my rights and The Company's duties with respect to my protected health information. Bulow Orthotic & Prosthetic Solutions reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, or asking for one at the time of my next appointment.

Consent for Contact

I, the undersigned, consent to be contacted by The Company by phone call, e-mail, US Postal Service or other means to follow-up on my care.

Consent to Provide Services and/or Products

I understand that by signing this agreement, I indicate my wish to purchase orthotic and/or prosthetic products or services, or both, from The Company. I understand that I am under the supervision and care of my attending physician. I understand that my physician has prescribed the orthosis/prosthesis noted as part of my treatment. I also understand that due to the nature of the products supplied by The Company that they cannot be returned.

Consent to Coordinate Care and Release of Medical Records

By signing below, I authorize all medical personnel to provide information to The Company concerning my medical history, as it may relate to my treatment. This includes collecting medical information from any physician, surgeon, medical facility and/or physical therapist seen by me. The Company will comply with all HIPAA rules and regulations.

Assignment of Benefits

I, the undersigned, hereby authorize The Company to request on my/our behalf and to collect directly all public and private insurance benefits due for products and/or services supplied to me by The Company. In the event payments for insurance benefits are made directly to any of the undersigned, the payee will endorse to The Company all checks for such payments.

_____ _____

Patient or Legal Representative Printed Name | Relationship to Patient

_____ _____

Patient or Personal Representative Signature | Relationship to Patient

_____

Date

SAVE RESET PRINT EMAIL