Able Prosthetic Care, Inc.

CONSENT TO TREAT & RELEASE OF INFORMATION

NOTIFICATION OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I have been given a copy of **ABLE PROSTHETIC CARE's** Notice of Privacy Practices and understand the rights contained therein. I also understand that it is my responsibility to notify the Privacy Officer in writing of any restrictions to the use of information in my patient file.

CONSENT TO PROVIDE TREATMENT

I hereby give consent to **ABLE PROSTHETIC CARE** to provide treatment and service(s) which have been prescribed by my physician. I further give consent to **ABLE PROSTHETIC CARE** to provide non-prescribed products or services which I have requested or which I have agreed to accept.

RELEASE OF INFORMATION & AUTHORIZATION

I hereby consent and permit a copy of this authorization and assignments to be used in place of this original signed document. I understand that this original will be placed in my patient file to be kept at the medical provider's office.

I hereby consent and grant permission for practitioners employed by **ABLE PROSTHETIC CARE** to discuss with my referring physician, primary care physician, physical therapist, occupational therapist, hospital, and/or rehabilitation staff any information relating to my care and prosthetic treatment. I hereby authorize any practitioner examining and/or treating me, 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 also authorize release of information contained within my file to any third party *(such as an insurance company or governmental agency)* for the purpose of explaining or justifying the course of treatment and to address any audit or inquiry by said third party. I understand that this is a Lifetime Release of Information unless I have submitted in writing a request to restrict use of information in my patient file. I hereby consent and authorize **ABLE PROSTHETIC CARE** to file medical claims for treatment, electronically or manually, to my insurance carriers for services rendered to me.

CONSENT TO PHOTOGRAPH

I hereby give consent to **ABLE PROSTHETIC CARE** to make and use any photographs and/or video deemed necessary to support my claim and to document my condition. I understand that these photographs and/or video will be treated in the same manner as all other documentation in my medical record as outlined above and may be used accordingly.

I have read, understand, and accept all the terms and conditions explained above.

Signature _____ Date _____

Name Printed _____