



(Patient's Printed Name)

**Assignment of Benefits/Authorization to Release Information**

I request that payment of authorized Medicare, Medicaid, or private insurance benefits be made to Hanger Prosthetics & Orthotics, Inc. for any covered services furnished by Hanger Prosthetics & Orthotics, Inc. I agree to pay to Hanger Prosthetics & Orthotics, Inc., the deductible and/or coinsurance on my claim.

I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents, Champus/TRICARE and its agents, or to any private insurance company any information needed to determine these benefits or the benefits payable for related services.

I further certify that the information provided by me is true, accurate and complete.

I understand and agree that I am responsible for the following expenses: any service my insurance plan deems "non-covered", all coinsurance and/or co-payment amounts, all deductibles, any amount that exceeds benefit limits under my insurance plan and any amount my insurance plan deems not covered because I was not insured on the date of service.

I acknowledge having received 1) a copy of Hanger Prosthetics & Orthotics, Inc.'s Notice of Privacy Practices (NPP), dated April 14, 2003, 2) Hanger's Main Patient Brochure which includes: Welcome Letter, Medicare Supplier Standards, Mission Statement, Bill of Rights, Warranty & Patient Responsibilities and 3) Hanger Prosthetics & Orthotics, Inc.'s Financial Policy.

\_\_\_\_\_  
**Patient or Responsible Party Signature**

\_\_\_\_\_  
**Date**

If Responsible Party, please complete below:

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Address

Relationship to Patient: \_\_\_\_\_

Reason for Patient's Inability to Sign: \_\_\_\_\_

For Notice of Privacy Practices only, describe the Responsible Party's authority to act on behalf of the patient: \_\_\_\_\_