SUMMIT
ORTHOTICS &
PROSTHETICS

Assignment of Benefits/Authorization to Release Information

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

I authorize Summit Orthotics & Prosthetics to request chart notes, etc from my Doctor's Office regarding services rendered to use with billing my insurance company or receiving prior authorization.

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 understand I am ultimately responsible for the balance of my account and agree to pay in a timely manner.

_____ _____

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:_____