Oertel Orthopedics
PROSTHETICS & ORTHOTICS
2095 Route 22 west, Union, NJ 07083-8401
TEL: (908) 688-1818 FAX: (908) 688-6616

CONSENT FOR TREATMENT / PATIENT ACKNOWLEDGEMENTS

- **GENERAL CONSENT AND AUTHORIZATION:** I authorize OERTEL ORTHOPEDICS, INC. and the affiliated physicians' participation in my care, to render medical care for my conditions, which may include diagnostic procedures and such other medical treatment as may be deemed advisable by the physician. I acknowledge that no guarantees have been made to me about the outcome of the medical treatment.

- **PROTECTED HEALTH INFORMATION**: I have received a copy of the HIPAA Notice of Privacy Practices for Protected Health Information. This Notice provides a complete description of the uses and disclosures of my Personal Protected Health Information (PHI). I reviewed the information before signing this form. I consent to OERTEL ORTHOPEDICS, INC or my physician participating in my care to release my PHI (either in writing or verbally) to carry out treatment or for payment of services. This includes any medical information which may be needed to process claims or conduct continued care planning.

- **CMS SUPPLIER STANDARDS**: The products and / or services provided to you by OERTEL ORTHOPEDICS, INC. are subject to the supplier standards contained in the Federal regulations shown at 42 Code of Federal Regulations Section 424.57(c). These standards concern business professional and operational matters (e.g. honoring warranties and hours of operation). The full text of these standards can be obtained at http://ecfr.gpoaccess.gov. Upon request we will furnish you a written copy of the standards.

- **ASSIGNMENT OF BENEFITS & AUTHORIZATION TO RELEASE INFORMATION**: I request that payment of authorized Medicare, Medicaid, or private insurance benefits be made to OERTEL ORTHOPEDICS, INC for any covered services furnished by OERTEL ORTHOPEDICS, INC. I authorized any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents, Champus/TRlCARE and its agents, or to any private insurance company any information needed to determine these benefits of the benefits payable for related services.

- **FINANCIAL POLICY**: I understand that I am responsible for an agree to pay OERTEL ORTHOPEDICS, INC. for the following expense: any service my insurance plan deems "non-covered", all coinsurance and / or co-payment amounts, all deductibles, any amount that exceeds benefits limits under my insurance plan and any amount my insurance plan deems not covered because I was not insured on the date of service. Verification of benefits and coverage is not a guarantee of payment. I understand that I am responsible for all charges, regardless of insurance coverage, and acknowledge receipt of OERTEL ORTHOPEDICS, INC. Financial Policy form.

_____ _____

Signature (Patient, Parent or Guardian) Date

_____ _____

Printed Name (Patient, Parent or Guardian) Relationship to Patient

If Responsible party, please complete below:
Responsible party address: _____
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: _____