INFORMATION RELEASE FORM

ASSIGNMENT OF BENEFITS

The customer requests that payment of authorized insurance benefits be made on the customer's behalf to Orthotic & Prosthetic Center of St Petersburg, Inc. for any services furnished.

The customer understands that the signature requests the payment by the insurance carrier be made directly to Orthotic & Prosthetic Center of St Petersburg, Inc.

MEDICAL INFORMATION RELEASE AUTHORIZATION

The customer authorizes any holder of medical information about the customer to release to Orthotic & Prosthetic Center of St Petersburg, Inc. or its agents any information needed to determine benefits payable for related services. The customer understands that the below signature(s) authorizes release of medical information necessary to pay the claim.

FINANCIAL RESPONSIBILITY CONSENT

The undersigned agrees to assume financial responsibility for any claim or portion of claim thereof, due Orthotic & Prosthetic Center of St Petersburg, Inc. for services provided, not covered by the insurance policy as of the date listed below. If the insurance company denies coverage for a product, the undersigned will assume financial responsibility for its payment. The undersigned acknowledges the responsibility for any payment not received from the insurance carrier within thirty (30) days from the date of service. The undersigned agrees to pay ALL reasonable fees of attorneys and/or collection agencies needed to affect collection of any delinquent charges outstanding on his/her account.

PLEASE PRINT

CUSTOMER'S NAME_____ **DATE**_____

PARENT, GUARDIAN OR AUTHORIZED NAME _____

RELATIONSHIP TO CUSTOMER _____

ADDRESS _____ **CITY** _____

STATE _____ **ZIP** _____ **PHONE** _____

CUSTOMER'S SIGNATURE _____

PARENT, GUARDIAN OR AUTHORIZED SIGNATURE _____