Patient Signature and Release Form

I acknowledge that I read, understand and agree to the terms of the following forms provided by Falk Prosthetics & Orthotics, Inc. (hereinafter "Falk P&O"):

-Notice of Privacy Practices
-Falk Prosthetics & Orthotics, Inc. Financial Policy
-Falk Prosthetics & Orthotics, Inc. Patient Information Form

Previous Brace History

Medicare, as well as other insurance companies, has specific guidelines with regard to supplying multiple orthotic/prosthetic devices to one patient. Sometimes, the second same or similar device provided within a specific period of time, regardless of who supplied these devices, will be denied for payment as it may be deemed not medically necessary. Due to these guidelines, it is critically important that you make us aware of your orthotic/prosthetic device history.

Please take a moment to consider your orthotic/prosthetic device history. This information is important for us to help you make informed decisions about any devices supplied to you now and what your financial responsibility may be.

Have you received an orthotic or prosthetic device within the previous five years?

_____ yes _____ no

If you answered yes, please supply us with the approximate date you received the device and describe the item received.

Date Item Received

I have read the above information and I understand its content. I further understand that if I have received previous orthotic or prosthetic devices, my insurance company may deny payment and I can be held financially responsible for the items received.

CONSENT FOR TREATMENT, AUTHORIZATION TO RELEASE INFORMATION INCLUDING PHOTOGRAPH AND ASSIGNMENT OF PAYMENT OF INSURANCE BENEFITS TO FALK P&O

Medicare DMEPOS Supplier Standards - The products and/or services provided to you by Falk Prosthetics & Orthotics, Inc. are subject to the supplier standards contained in the Federal regulations shown at 42 Code of Federal Regulations Section 424.57©. 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.

I acknowledge and I authorize Falk P&O to deliver, teach, administer, or perform, as necessary, the product and treatment prescribed by my Health Care Provider. I authorize the use of the information provided on the **Falk Prosthetics & Orthotics, Inc. Patient Information Form** or Hospital/Facility Face Sheet for hospitalized patients and I allow the release of my medical information to all my insurance companies. I hereby acknowledge that I have received a copy of the **Notice of Privacy Practices for Falk P&O**. In addition, I agree that if Falk P&O or my Health Care Provider takes a photograph of me in connection with a product that I have received from them, I give Falk P&O permission to use this photograph in their attempt to obtain payment for the product. **I authorize Falk P&O to submit a claim, for a product I have received from them, to my insurer on my behalf, and I assign the benefits payable by my insurer for such product to Falk P&O. I understand and agree that I am personally and fully responsible for, and I agree to pay to Falk P&O, any portion of the amount due for such product not paid by my insurer, whether resulting from deductibles, co-pays, or otherwise.**

Patient's Signature Date

Signature of Patient Representative Relationship of Patient Representative to Patient