PATIENT NOTIFICATIONS AND OFFICE POLICIES

FINANCIAL POLICY

I understand that I am personally responsible for direct payment of all charges incurred by me for services performed and expenses incurred on my behalf by Howard Orthotics & Prosthetics, LLC. I acknowledge that I am personally responsible for payment of invoices rendered and in the event that my health insurance carrier or other source pays a portion of the liability, I will continue to be personally responsible for the net balance due and will make timely payment. Out-of-pocket expenses such as deductibles, coinsurance, and/or co-payments are due at the time of service. In the event that my insurance company pays me directly, I hereby agree to endorse any checks sent to me for such billing to: Howard Orthotics & Prosthetics, LLC. I hereby request that my insurance carrier tender direct payment to Howard Orthotics & Prosthetics, LLC. I understand that I will be expected to pay the balance, in full, if Howard Orthotics & Prosthetics, LLC does not receive payment from my insurance company within the New York State mandated 45 day period starting from the date of service. I understand that overdue balances will incur a 2% interest charge monthly. If my account becomes delinquent and is forwarded to a collection agency, 23% of the pre-collection balance will be added to my account to cover collection expenses.

AUTHORIZATION FOR RELEASE OF RECORDS

I authorize Howard Orthotics & Prosthetics, LLC to release requested information related to my care to my insurance company, physician, government agencies, or others responsible for my medical care.

CONSENT FOR TREATMENT

I hereby acknowledge that there have been no guaranties or assurances given to me as to the results that will be achieved due to the treatment performed by Howard Orthotics & Prosthetics, LLC. I hereby authorize Howard Orthotics & Prosthetics, LLC to perform treatments in compliance with the treatment prescribed by my physician.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I have received a copy of Howard Orthotics & Prosthetics, LLC notice of Privacy Practices with the effective date of April 1, 2003.

MISSED APPOINTMENT POLICY

I understand that in the instance of a cancellation without 24 hours notice, or No-Show to a scheduled appointment, Howard Orthotics & Prosthetics, LLC reserves the right to charge a $50 fee, which is NOT covered by my health insurance plan or insurer.

I have read and fully understand and acknowledge the patient notifications and office policies of Howard Orthotics & Prosthetics, LLC.

Patient Signature or Authorized Party	Self or Relation to Patient	Date
HOP Representative Signature		Date

HOWARD ORTHOTICS & PROSTHETICS, LLC
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