CAPITAL ORTHOTIC PROSTHETIC ASSOCIATES
8 CORPORATE CIRCLE, KARNER PARK, ABANY, NY 12203
(518) 456-1145 FAX (518) 456-0942

HIPPA ACKNOWLEDGEMENT/PATIENT PAYMENT POLICY/ASSIGNMENT OF BENEFITS FORM

HIPPA ACKNOWLEDGEMENT:

I hereby give my consent for Capital Orthotic Prosthetic Associates to use and disclose mu health information which specifically identifies me, or which can reasonably be used to identify me to carry out treatment, payment and health care operations. I understand that if I refuse to sign, Capital Orthotic Prosthetic Associates can refuse to treat me. I have been informed that Capital Orthotic Prosthetic Associates has prepared a notice which more fully describes the uses and disclosures that can be made of my health information. I understand that Capital Orthotic Prosthetic Associates has reserved the right to change their privacy practices and I can obtain such changed notice upon request.

PATIENT PAYMENT POLICY

Capital Orthotic Prosthetic Associates will bill your insurance if coverage is provided with the understanding that I am fully responsible for all charges incurred. Balances are to be paid in full within 30 days unless otherwise agreed to in writing prior to delivery of services. If necessary, accounts may be turned over to an outside collection agency for further collection action.

NO-FAULT INSURANCE LAW ASSIGNMENT OF BENEFITS FORM

I, _____ ("assignor") herby assign to Capital Orthotic Prosthetic Associates ("assignee") all rights, privileges and remedies to payment for healthcare services provided by assignee to which I am certified under Article 51(the No-Fault Statute) of the Insurance Law. The Assignee herby certifies that they have not received any payment from or on behalf of the assignor and will not pursuit payment directly from the Assignor for injuries sustained due to a motor vehicle accident which occurred on _____, notwithstanding any other agreement to the contrary. This agreement may be revoked by the Assignee if the Insurance Company refuses payment for services provided by Capital Orthotic Prosthetic Associates and I understand that I would be responsible for payment for the services and/or items I receive form Capital Orthotic Prosthetic Associates.

I have read and agree to the above policies and financial responsibilities:

_____ Date:_____
Signature of Patient/Responsible Party

_____
Printed Name of Patient