Bay Orthopedic & Rehabilitation Supply Co., Inc.

Consent to Treatment/Assignment of Benefits/Authorization to Release Information/Receipt of Privacy Practices, Medicare Standards, and Patients Rights Policy

I hereby consent to treatment in accordance with my doctor's prescription.

I hereby certify that I have received a copy of the "Notice of Privacy Practices" which describes how Bay Orthopedic & Rehabilitation Supply Co., Inc. may disclose my protected health information in carrying out my treatment, collection of my bills, or health care operations and for other purposes that are permitted or required by law.

Bay Orthopedic & Rehabilitation Supply Co., Inc. reserves the right to change the privacy practices that are described in its Notice of Privacy Practices. Bay Orthopedic & Rehabilitation Supply Co., Inc. also reserve the right to apply these changes retroactively to PHI received before the change in privacy practices. I understand that I may obtain a revised Notice of Privacy Practices by calling our office at 631-271-0825, and requesting a revised copy be sent in the mail or by asking for one at the time of my next appointment.

I received Medicare's 30 Supplier Standards by which our facility has agreed to abide, and I received Bay Orthopedic & Rehabilitation Supply Co., Inc's Patients Rights Policy.

I hereby authorize Bay Orthopedic & Rehabilitation Supply Co., Inc to release necessary medical information to my insurance carrier(s) to process my medical claim. I also authorize my insurance carrier to pay benefits directly to Bay Orthopedic & Rehabilitation Supply Co., Inc. I request that payment of authorized Medicare, Medicaid, or private insurance benefits be made payable to Bay Orthopedic & Rehabilitation Supply Co., Inc for any covered services furnished by Bay Orthopedic & Rehabilitation Supply Co., Inc. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents in order to determine these benefits or benefits for related services.

I understand and agree that I am responsible for the following expenses: any service my insurance plan deems "non-covered", all coinsurance and/or co-payment amounts, all deductibles, any amount that exceeds benefit limits under my insurance plan and any amount my insurance plan deems not covered because I was not insured on the date of service.

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Signature of Patient or Personal Representative

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Name of Patient or Personal Representative

_____

Date