Assignment of Benefits / Authorization to Release Information

_____ _____
(Patient Name) (Patient I.D.#)

I request that payment of authorized Medicare, Medicaid, or private insurance benefits be made to Dream Team Prosthetics LLC for any covered services furnished by Dream Team Prosthetics LLC. I agree to pay to Dream Team Prosthetics LLC. the deductible and/or coinsurance on my claim or any of my dependent(s). I further agree that should the amount be insufficient to cover the entire orthotic or prosthetic expense, I will be responsible for payment of the difference, and if the nature of the disability be such that it is not covered by the policy, I will be responsible to Dream Team Prosthetics LLC for payment of the entire bill.

I also understand that telephone inquiries to my insurance company ARE NOT a guarantee of coverage/ benefits. We (Dream Team Prosthetics LLC) have attempted to estimate your balance due; however, after review by your insurance company, you may owe an additional amount.

I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents, Champus/TRICARE and its agents, or to any private insurance company any information needed to determine these benefits or the benefits payable for related services.

I further certify that the information provided by me is true, accurate and complete. If this is a private insurance claim, I further agree to be responsible for the full amount of the charges from the date of delivery if my private insurance company does not pay for the charges in a timely manner, or my physician or I fail to provide within (30) days the information necessary to submit the claim for payment.

☐ **By checking this box & signing below, I acknowledge receiving a copy of Notice of Privacy Practices(NPP)**

Patient or Representative Signature: _____ Date: ___/___/___

If Representative, please complete below.

Printed Name: _____

Address: _____

Relationship to Patient: _____Reason for Patient's Inability to Sign: _____

For Notice of Privacy practices only, describe the Personal Representative's authority to act on behalf of the patient:

_____

Please list any individuals we may speak to or release information to:
I authorize the following individuals, including myself to have access to information regarding self/patient.

_____ _____
Please print name relationship to patient

_____ _____
Please print name relationship to patient

Signature: _____ Date: ____/____/____