



PATIENT ACKNOWLEDGEMENT FORM

As part of the admission process, you will be receiving information on several policies and procedures that we have implemented to ensure your treatment while in our care is of the highest quality. This acknowledgement indicates your receipt of such information at the time of your initial registration or patient contact.

_____ **Privacy Act (HIPPA)** – This details our policy and your rights to your private health care information.

_____ **Warranty Policy** – Describes **AOPI's** policies with respect to the warranty period and repairs/adjustments. (Will be issued at delivery, if applicable)

_____ **Payment and Policy Agreement** – This explains **AOPI's** policies with respect to billing your insurance and collecting applicable co-pays and deductibles.
YOUR INSURANCE PROVIDER AND AOPI DO NOT GUARANTEE PAYMENT OF SERVICES.

_____ **Patient Complaint Process** – This notifies you of our complaint and resolution process.

_____ **Medicare Supplier Standards** – Outlines standards that are to be maintained by **AOPI** as a Medicare provider.

_____ **Consent to Treat** – I hereby authorize **AOPI** to provide requested orthotic and/or prosthetic services.

_____ **Assignment of Benefits** - I hereby authorize **AOPI** 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 **AOPI**.

YES / NO Have you ever received a like or similar device from either **AOPI** or any other provider? If so, please state when received _____

YES / NO Are you currently residing in a nursing home?

YES / NO Do you have surgery scheduled to treat the same condition for which this device will be utilized?

I request that payment of authorized insurance benefits be made to **AOPI** on my behalf for any services furnished to me by **AOPI**. I authorize anyone who holds medical or other information about me to release that information to my insurance provider and its agents in order to determine these benefits or benefits for related services. I, the undersigned, have received, read and understand these policies and agreements and hereby consent to the above as indicated by my initials. I also attest that the above questions have been answered truthfully to the best of my knowledge.

Signature of responsible party

Date