Notification of Information Practices

The purpose of the consent form is to inform you, the patient, how our personal health information is used and/or disclosed by this provider or organization. We want you to be fully aware of what we do with your information so that you can provide us with your consent in order for us to treat our health care needs, receive payment for services rendered and allow administrative and other types of health care operations, to happen, which are part of normal business activities of the provider or organization. I request the following to the use or disclosure of my health information. Please provide your signature below to indicate understanding and notification of information practices related to our service.

I request the following restrictions to the use or disclosure of my health information.

One Time Authorization

Request for Provision of Services

I understand that by signing this agreement, I indicate my wish to purchase orthotic and/or prosthetic products or services, or both from Dickson O & P, LLC or its affiliates. I understand that I am under the supervision and control of my attending physician. I understand that my physician has prescribed the orthotic/ prosthesis noted as part of my treatment. **I also understand that due to the nature of the products supplied by Dickson O & P, LLC that they may not be returned.**

Assignment of Benefits

The undersigned hereby authorize Dickson O & P, LLC to request on my/our behalf and to collect directly all public and private insurance benefits due for products and/or services supplied patient by Dickson O & P, LLC. In the event payments for insurance benefits are made directly to any of the undersigned, the payee will endorse to Dickson O & P, LLC all checks for such payments.

Responsibilities

As the responsible party, I understand that I am personally responsible for the entire amount of my claim and that insurance benefits may be limited or non-existent. I agree to notify Dickson O&P, LLC of any change in insurance coverage of status. I understand that the entire amount of the fees for your services and/or Orthotic and Prosthetic devices is my personal responsibility even though this may or may not be covered by insurance. If you bill the insurance company directly, I understand that I am to pay my portion of the bill when your service is rendered. I further agree to personally pay within thirty (30) days any portion of the bill that is outstanding.

In the event this bill is turned over to a third party for collection, I agree to pay all reasonable collection fess including attorney and Court cost.

Should you make payment by check and it is returned, a fee of $30 will be charged to your account.

Clinical Photograph Release

I understand that Dickson O&P, LLC may obtain a photograph of me for clinical purposes and/ or marketing. Marketing purposes include but not limited to, newsletters, web, and social media. For clinical purposes this photograph of me will remain in my records and may be forwarded to my treating medical professional(s).

☐ Marketing and Clinical ☐ Clinical Only ☐ DECLINE

_____	_____	_____
Signature of Patient or legal representative	DATE	Dickson O & P, LLC Representative