ALABAMA ORTHOTICS & PROSTHETICS, INC.

Authorization to Release or Receive Medial Information
And
Authorization of Assignment of Benefits

We strongly feel that all patients deserve from us the very best medical care that we can provide. Further, we feel that everyone benefits when definitive financial arrangements are agreed upon. Accordingly, we have prepared this material to acquaint you with our policy.

Our professional services are rendered to you, not the insurance company. Your insurance is a ***contract between you, your employer and the insurance company. We are not a party to that contact. NOT ALL services are covered by all contracts.*** Therefore, payment for treatment is **your** responsibility.

Please read and sign the following:

1) I authorize this office to release or receive any information necessary to expedite insurance claims.
2) I hereby authorize this office to bill my insurance company directly for their services.
3) I authorize payment directly to Alabama Orthotics & Prosthetics, Inc., of any insurance benefits otherwise payable to me.
4) In the event I receive payment from my insurance carrier, I agree to endorse any payment I receive over to Alabama Orthotics & Prosthetics, Inc., for which these fees are payable.

I understand that I am directly and fully financially responsible to Alabama Orthotics & Prosthetics, Inc., for charges not covered by my insurance. I futher understand that such payment is not contingent on any settlement, judgement or insurance payment by which I eventually recover said fee. I realize that if my insurance company fails to pay my balance in full, or there is no payment made within **60days**, it is my responsibiliby to pay my Orthotic/Proshetic bill directly.

I futher understand and agree, that if I fail to make timely payments on my account, I will be responsible for any and all resasonable costs of collection, including filing fees as well as reasonable attorney's fee. There will be a $35.00 charge on all returned checks and a $20.00 charge on all delinquent accounts, which must also be paid.

A Photostatic copy of these authorizations and agreements shall be valid as the original.

Signature:____________________________________ Date:__________________________

Witness:__________________________________

PLEASE PRESENT BOTH YOUR INSURANCE CARD AND YOUR DRIVER'S LICENSE SO WE MAY MAKE A COPY FOR YOUR RECORDS.