Prosthetics By Lynda

345 NE Norton Ave
Bend, OR 97701

PATIENT NAME: _______________________________

ADDRESS: ______________________ CITY __________________ STATE _______ ZIP ______________

HOME PHONE: ________________________CELL PHONE:_________________________________

WORK PHONE: ________________________EMERGENCY CONTACT PHONE:______________________

EMAIL ADDRESS: _____________________________________ SS#____________________

GUARANTOR: __________________________________

RELATIONSHIP TO PATIENT: ____

GUARANTOR ADDRESS: ____

HOME PHONE: _______________________________CELL PHONE:________________________

GENDER: ___________ MARITAL STATUS: _____________ DOB: _________________________

REFERRING PHYSICIAN: _____________________________________PHONE:________________

PRIMARY CARE PHYSICIAN: ___________________________________PHONE:________________

PRIMARY INSURANCE: ____

ADDRESS:____PHONE:____________

POLICY #:____ GROUP #________________________

NAME OF INSURED: ____RELATIONSHIP:________

DOB: ___________________________ SS #:_______________________________

In consideration for professional services rendered, I hereby assign benefits due me covering the services under the above insurance policy to Prosthetics by Lynda. I agree that should the amount be insufficient to cover the entire expenses for the professional services, I will be responsible for payment of the difference. I agree to pay for all services rendered. A charge of 2.5% per month will be charged on any unpaid balance, plus a monthly service fee of $8.00.

In the event legal action should become necessary to enforce payment of any charges, I agree to be responsible for and pay all attorneys' fees, court cost and other collections costs incurred.

____________________________________ ___________________________________

Patient Signature Today's Date

• Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, and the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you to read it carefully and completely before signing this Consent.

• Purpose of Consent: By signing this form, you consent for to use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

I authorize Prosthetics by Lynda to leave messages on my home phone/cell phone or contact me by e-mail at ____.

"The products and/or services provided to you by Prosthetics by Lynda are subject to the supplier standards contained in the Federal regulations shown at 42 Code of Federal Regulations Section 424.57(c). These standards concern business professional and operational matters (e.g., honoring warranties and hours of operation). The full text of these standards can be obtained athttp://ecfr.gpoaccess.gov. Upon request we will furnish you a written copy of the standards."

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I authorize my insurance company to pay benefits directly to Prosthetics by Lynda. I understand my insurance company may not pay for services that are not a covered benefit or are not considered medically necessary. I also understand that there may be benefit limitations with no-fault carriers as deductibles and benefit maximums may apply. I agree to be financially responsible for all services provided by Prosthetics by Lynda.

I HAVE READ, UNDERSTOOD, AND HEREBY AGREE TO ALL OF THE TERMS STATED ABOVE.

____ _______________________

PATIENT OR AUTHORIZED REPRESENTATIVE SIGNATURE: DATE