PATIENT ACKNOWLEDGMENTS/ASSIGNMENT OF BENEFITS/AUTHORIZATION TO RELEASE INFORMATION

Assignment of Benefits: I request that payment of authorized Medicare, Medicaid, or private insurance benefits be made to **Human Technology and Its Affiliates (Human Technology)*** for any covered services furnished by Human Technology. I agree to pay to Human Technology, the deductible and/or coinsurance on my claim.

Authorization to Release Information: 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 of the benefits payable for related services.

General Consent & Authorization: I authorize Human Technology and the affiliated physicians' participation in my care, to render medical care for my conditions, which may include diagnostic procedures and such other medical treatment as may be deemed advisable by the physician. I acknowledge that no guarantees have been made to me about the outcome of the medical treatment.

Financial Policy: I understand and agree that I am responsible for the following expenses: any service my insurance plan deems "non-covered", all coinsurance and/or co-payment amounts, all deductibles, any amount that exceeds benefits limits under my insurance plan and any amount my insurance plan deems not covered because I was not insured on the date of service.

I further certify that the information provided by me is true, accurate and complete. I further agree to and authorize Human Technology and Its Affiliates to contact me by telephone.

I hereby acknowledge receipt of:

- Patient Information Brochure including: Mission, Medicare Supplier Standards, Patient Bill of Rights and Responsibilities, Equipment Warranty Information, and Complaint Resolution Protocol.
- HIPAA Notice of Privacy Practices (NPP), dated November 20, 2023

HIPAA Regulations limit who Human Technology can speak with regarding your PHI that may consist of appointments and other information regarding your care. Please list whom we can release information to:

Name: ______________________ Relationship: ______________________

Name: ______________________ Relationship: ______________________

______________________________ ______________

Patient or Responsible Party's Signature Date

____

Patient's Printed Name

If Responsible Party, print name: ______________________________

______________________________ ______________

Address Relationship to Patient

Reason for Patient's Inability to Sign: ______________________________

***Human Technology & Its Affiliates** *(Human Technology Inc, Greer Orthotics & Prosthetics, Inc., Murphy's Orthopedic & Footcare, Inc.)*