  **CONSENT FOR TREATMENT,**

**AUTHORIZATION TO RELEASE INFORMATION**

**ACKNOWLEDGEMENT OF BILLING, WARRANTY, AND RETURN POLICIES**

**\*Please Initial**

I authorize treatment from Allen Orthotics & Prosthetics to perform appropriate assessment and approve the treatment procedures recommended by the treating practitioner/s.

I authorize the release of any medical or other information **to** and **from** Allen Orthotics & Prosthetics necessary to facilitate the care including, but not limited to, medical advice, treatment history, clinical records, diagnosis, and/or prognosis.

I acknowledge my understanding of General Billing, Warranty, and Return Policies.

I certify that the information provided by me is true, accurate, and complete.

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

**Patient / Responsible Person’s Signature**  **Date**

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship to Patient**

**24 HOUR CANCELLATION & NO SHOW FEE POLICY**

Each time a patient misses an appointment without providing timely notice, another patient is prevented from receiving care. **Therefore, Allen Orthotics & Prosthetics reserves the right to charge a fee of $40.00 for all missed appointments (“no show”) and appointments that, absent a compelling reason, are not canceled with 24-hour advance notice. “No Show” fees will be billed to the patient, their guardian, or other responsible parties. This fee is not covered by insurance and must be paid prior to your next appointment. Multiple “no shows” may result in termination from our practice**. Thank you for your understanding and cooperation as we strive to best serve the needs of our patients. By signing below, you acknowledge that you have received this notice and understand this policy.

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

**Patient / Responsible Person’s Signature**  **Date**

**HIPAA NOTICE AND ACKNOWLEDGMENT**

I acknowledge that I have had the opportunity to review and/or obtain a copy of the facility’s Notice of Privacy Practices.

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

**Patient / Responsible Person’s Signature**  **Date**

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship to Patient**

Internal use – received/reviewed by: \_\_\_\_\_\_\_\_

Rev. 2022

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