LIMBCARE inc.
PROSTHETICS & ORTHOTICS OF GEORGIA

ASSIGNMENT OF BENEFITS
RELEASE OF INFORMATION AUTHORIZATION

Patient Name: _____ Date: _____

I authorize my private insurance companies (Medicare, Medicaid, VA, Voc Rehab, WC, etc.) to make payment to Limbcare Prosthetic & Orthotics of Georgia, Inc. for all services provided by Limbcare Prosthetics & Orthotics of Georgia, Inc.

I give permission for my physicians and any holder of my medical records to be released to Limbcare. I will provide all information needed to process my claims in a timely manner.

I understand that I am responsible for all products/services provided to me, including the balance remaining after payment of insurance payments. If my private insurance does not pay I will be responsible for full payment of balance (including co-insurance, deductibles, and non-covered services).

I have received Limbcare Prosthetics & Orthotics "Notice of Privacy Practices" (NPP). I have also received the following information: Welcome Letter, Mission Statement, Bill of Rights, warranty, Medicare Supplier Standards (Medicare patients), Patient's Responsibility. The information I have provided to Limbcare is true and accurate.

_____ _____
Patient signature or responsible party **Date**

_____ _____
Relationship to patient **Date**

_____
Patient unable to sign for above reason