Patient Registration Signature Form

- **Consent for Treatment:** I, the undersigned, hereby consent to treatment under the recommendations and instructions of the physician/therapist.
- **Release of Medical Records information:** I authorize any holder of medical or other information (such as photos) about me to release such information for necessary completion of my insurance claims to Macy O&P. A photocopy of authorization is to be considered valid.
- **Assignment of Insurance Benefits:** I hereby authorize direct payment to Macy O&P for my insurance benefits herein specified and otherwise payable to me.
- **Wavier of Liability or Guarantee of Account:** I certify that I have been given a copy of Macy O&P Financial Policy and understand I will be financially and legally responsible for charges not covered by this assignment. The undersigned further agrees to pay all costs of collection of any such balance, including responsible attorney's fees.
- **Notice of Privacy Practices:** By signing below, I certify that I have been offered a copy of Macy O&P's Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of Macy O&P's healthcare operations. The Notice of Privacy Practices also describes my rights and Macy O&P's duties with respect to my protected health information.

  Macy O&P reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling (860) 333-5558 and requesting a copy be sent to me.

- **Medicare Part B Patient Authorization and Release:** I certify the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made on my behalf to Macy O&P for any services furnished to me. I authorize any holder of medical information about me be released to the Centers for Medicare & Medicaid Services and its agents, and any information needed to determine these benefits or the benefits payable for the related services. I also authorize automated claims to be submitted electronically to Medicare on my behalf.
- **Medicare Supplier Standards:** I certify that I have been offered a copy of the Medicare DMEOPS 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).

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Name of Patient or Personal Representative	Description of Personal Representative Authority
______________________________	______________________________
Signature of Patient or Personal Representative	Date