Patient Authorization, Consent & Receipt of Privacy Policy

1. *Consent for Treatment*
   I voluntarily give my permission to the health care providers of Streamline Orthotics & Prosthetics, LLC ("Streamline") to provide services to me. I understand that by signing this form, I am authorizing them to treat me for as long as I seek care from Streamline providers, or until I withdraw my consent in writing.

   I, as the patients' guardian, voluntarily give my permission to the health care providers of Streamline Orthotics & Prosthetics, LLC ("Streamline") to provide services to my child. I understand that by signing this form, I am authorizing them to treat my child for as long as I seek care from Streamline providers, or until I withdraw my consent in writing. Additionally, I understand that since my child is working with a therapist at his/her school, I may not be present for the evaluation or delivery of the orthotics. I am authorizing the therapist working with my child to act on my behalf for these services and understand that I may contact or make an appointment at any time with Streamline in order to address any questions or concerns I may have regarding the fit and function of the orthotics.

2. *Release of Information and Authorization to Submit Claim*
   I hereby authorize Streamline to release any medical information concerning my care, including copies of medical records and/or billing information pertaining to my medical care to individuals or representatives of agencies or organizations in connection with obtaining payment for services rendered to me. I certify that the information given by me in applying for payment is correct, and I authorize Streamline to submit all necessary claims on my behalf. I acknowledge that this authorization has no expiration date.
3. *Assignment of Insurance Benefits/Financial Responsibility*
   I hereby assign and authorize direct payments to Streamline for all services rendered. I acknowledge that I am legally responsible for all charges in connection with the care and treatment provided by representatives of Streamline. I understand that my insurance provider may not approve or reimburse my medical services in full, and that I am legally responsible for fees not paid in full, co-payments, and policy deductibles. In addition, I understand that all unpaid balances will incur a monthly finance change and any legal or collection charges involved.
4. *Acknowledgement of Notice of Privacy Practices (NPP)*
   I hereby acknowledge that I have received summary of Streamline's Privacy Practices and that I may request a copy of the full NPP by contacting Streamline.
5. *Statement to Permit Payment of Medicare Benefits to Provider, Physician, or Patient*
   I request that payment of authorized Medicare benefits either be made to me or on my behalf for any services provided to me by Streamline. I authorize any holder of medical or any other information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or benefits for related services.

6. I acknowledge that I have received a copy of the following:
   - Streamline Patient Rights Policy
   - Streamline Financial Policy; Warranty and Return Policies
   - Medicare Supplier Standards (full version available upon request, or at www.palmettogba.com)
   - General Wear and Care Guidelines (when to contact Streamline with a problem)
   - How to contact Streamline during regular business hours and after hours/emergency; how to submit a complaint to Streamline.

I agree to the above terms and conditions set forth by Streamline. If I am the patient's authorized representative, I certify that I am duly authorized on behalf of the patient to execute such an agreement.

_____ _____

Signature of patient or representative *Date*