A Specialized Approach to Prosthetics, Inc.
500 Spring Hill Drive Suite 200
Spring, TX 77386

CONSENT TO TREAT FORM

I, _____ (patient name) am in need of a prosthesis/orthosis and hereby consent to ASA Prosthetics ("ASAP") providing the care and services attendant to my prosthetic needs. I understand that the practice of prosthetics/orthotics is not an exact science and that use of a prosthesis/orthosis could involve risk of injury or severe bodily harm. I acknowledge that no guarantees have been made to me as to my ability to use my ASAP prosthesis/orthosis once the fitting is complete.

Assignment of Benefits. As courtesy to patients and their families, ASAP submits claims to many third-party payors. I request that payment of authorized Medicare, Medicaid, or private benefits be made to A Specialized Approach to Prosthetics (ASAP), L.L.C. for any covered services furnished to me by ASAP. If my insurance carrier pays me directly, I agree to forward all funds to ASAP within ten (10) working days. Under some plans, including Medicare, I understand some of the services I may receive may NOT be covered. I agree I am responsible for paying all non-covered amounts unless otherwise provided by law, regulation or ASAP contractual relationships. I agree to be responsible for the full amount of charges from the date of delivery if my third-party payor does not pay for the charges in a timely manner or my physician or I fail to provide within thirty (30) days the information necessary to submit the claim for payment. I understand if I chose to self-pay for services and not file with a third-party payor I am responsible for full payment at the time services are rendered unless payment arrangements have been made in advance.

Waiver and Release for Non-Prosthetic Care. I further understand that ASAP's sole business is to fit prostheses/orthotics. Prior to coming to ASAP, I have been instructed on safe transfer techniques. If at any time during my prosthetic/orthotic fitting I need assistance to transfer from chair, wheelchair, table, or commode, I hereby release ASAP, its directors, officers, and staff from any liability associated with an injury I may incur during any such transfer whether assisted or not.

Authorization to Request Medical Records. I hereby authorize my attending physician to release all medical records pertaining to my prosthesis/orthosis ASAProsthetics ("ASAP").

Release of Records. I authorize ASAP to release to any governmental health care program and its agents, or to any private insurance company or its agents, any information needed to determine my benefits or the benefits payable for ASAP services. I understand further that the information authorized for release may include records which may indicate the presence of a communicable or veneral disease which many include but is not limited to disease such as hepatitis, syphilis, gonorrhea, and the Human Immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).

Authorization to Release Information. I understand that there are some circumstances that may require you to contact me regarding my care. By initialing and signing below I authorize ASAP to contact me at the following:

	Home Number	Mobile Number	Email Address
Appointments			
Treatment Plans/Instructions			
Billing/Account Information			
I do NOT want any voice messages left and/or e-mail			

I authorize ASAP to share information regarding my treatment or payment for treatment with the following individuals:

- ☐ My spouse or partner (name) _____
- ☐ My child (name) _____
- ☐ Other individual (name) _____
- ☐ None

_____ _____

Patient Signature (or Parent/Guardian or Representative) Date