



Prosthetic Illusions
aka Rocky Mountain Anaplastology, Inc.
Barbara Spohn-Lillo , CCA, Ocularist
3405 S. Yarrow St., Suite C
Lakewood, CO 80227

Phone: 303.973.8482
Fax: 303.973.8468
www.ProstheticIllusions.com

**** Please read and sign below**

CONSENT FOR TREATMENT
AUTHORIZATION TO RELEASE INFORMATION FOR PAYMENT OF SERVICES

I, the undersigned patient / responsible party consent to the medical procedures, treatments and examinations to be provided for the rendering of an artificial prosthesis and / or related services from this date forward.

I, the undersigned patient / responsible party am responsible for supplying the necessary insurance and physician information in order for Prosthetic Illusions to obtain a physician’s referral, as well as insurance authorization in order to proceed with the above mentioned services.

I, the undersigned patient / responsible party acknowledge being given a copy of the Notice of Privacy Practices and understand the terms and conditions written therein.

I, the undersigned patient / responsible party request that payment of authorized benefits be made on my behalf for any services furnished me by Prosthetic Illusions, Inc. I authorize any holder of medical or other information about me (including but not limited to chart notes, photographs and/or models) which are obtained in connection with my treatment be released to the appropriate insurance agency and its agents as needed to determine these benefits or benefits related services. I permit a copy of this authorization to be used in place of the original.

I, the undersigned patient / responsible party authorizes Prosthetic Illusions, to disclose financial and medical information and records to: my employer and third party payers, who are or may be responsible for payment of all or a portion of the charges; to other health care accreditations, audits, certification, appeal councils, and peer or utilization reviews.

The undersigned patient / responsible party acknowledges reading the above information in its entirety and agrees to the terms set forth in this form:

Print name of patient or responsible party

Signature of patient or responsible party

Date of signing

Signature of witness – Prosthetic Illusions

Date of signing