



**P R O S T H E T I C
I L L U S I O N S**
Rocky Mountain Anaplastology, Inc.

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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.

I, the undersigned patient / responsible party, in order to assist in the dissemination of medical and scientific knowledge, or in the improvement of medical diagnosis and treatment, authorize Prosthetic Illusions / Rocky Mountain Anaplastology, Inc., to release, publish, display, or otherwise use photographs, models and / or videotapes which are obtained in connection with my treatment. It is understood and agreed that names will not be used or in any way disclosed in connection therewith.

The products and/or services provided to you by supplier legal business name or DBA are subject to the 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). The full text of these standards can be obtained at <http://ecfr.gpoaccess.gov>. Upon request we will furnish you a written copy of the standards.

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

Print Name of Witness (Prosthetic Illusions)

Signature of witness

Date