TOTAL CARE
ORTHOTICS and PROSTHETICS

6565 S. Yale, Ste 909
Kelly Medical Building
Tulsa, OK 74136

FINANCIAL RESPONSIBILITY AGREEMENT & AUTHORIZATION TO TREAT

Total Care Orthotics and Prosthetics agrees to provide prosthetic/orthotic/pedorthic device(s) and/or service(s) to me as prescribed by my physician(s).

I consent to the prescribed treatment and am ultimately responsible for the balance of my account for any professional services rendered and prosthetic/ orthotic products provided regardless of my insurance status.

All information and documentation provided to **Total Care Orthotics and Prosthetics** is true and accurate to the best of my knowledge.

If the device is casted for but not manufactured or purchased then returned, an evaluation fee of $125.00 applies. If no device is provided, there will be an office visit fee of $50.00 which is non-refundable.

To comply with Oklahoma law, I acknowledge that custom-made prosthetic/orthotic appliances are NON-REFUNDABLE.

In the event that I do not make payment as demanded, I agree to pay a monthly finance charge of 1.5% of the outstanding unpaid balance.

In the event that legal action is required by **Total Care Orthotics and Prosthetics** to enforce my obligation for the charges, I will be responsible for all the reasonable attorney fees, court costs and other collection expenses associated with enforcement of the charges incurred.

Sign if you agree: _____ **Date:** _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO THE INSURANCE CARRIER AND ASSIGNMENT OF BENEFITS TO PROVIDER

Total Care Orthotics and Prosthetics agrees to submit charge(s) and any required documentation to my insurance carrier for payment on my behalf. I understand benefits quoted to me are only a summary of what is shared by my insurance carrier and is not a guarantee of coverage, final determination is made only after a claim is processed by my insurance and I agree to be responsible for non-covered services.

I hereby authorize the release of any information necessary to file a claim with my insurance carrier and assign benefits otherwise payable to me to: ***Total Care Orthotics and Prosthetics*** as payment toward the total charges for the product(s) and or service(s) rendered.

I understand that I am ultimately responsible for the deductible, copayment, and any charges not covered by my insurance carrier. I authorize **Total Care Orthotics and Prosthetics** to initiate a complaint to the Insurance Commissioner for any delayed or improperly processed claims on my behalf. A photocopy of this Assignment shall be considered as effective and valid as the original.

Sign here if you agree: _____ **Date:** _____

918.502.5975 TEL
918.502.5980 FAX

www.totalcareop.com