Authorization for Release of Information and Assignment of Benefits

I hereby authorize The Dallas Limb Restoration Center to furnish information to my insurance carriers and my referring doctors on behalf of myself and/or my dependents; and hereby assign The Dallas Limb Restoration Center all payments for medical services rendered to myself or my dependents. I understand that I am responsible for payment of services as determined by my insurance company. I permit a copy of this authorization to be used in place of the original.

Patient Name: _____

Patient Signature: _____ Date:_____

Acknowledgement of Receipt of Notice of Privacy Practices

I _____ acknowledge that I have received
(Printed Name of Patient)
a copy of The Dallas Limb Restoration Center "Notice of Privacy Practices". This notice describes how The Dallas Limb Restoration Center may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

_____

(Signature of Patient, or Legal Personal Representative) Date

_____

(Relationship to Patient if Applicable)

Acknowledgement of Receipt of Office Policies and Procedures, Including Narcotics Policy

I affirm that I have read and understand the office policies and procedures of The Dallas Limb Restoration Center

_____

(Signature of Patient, or Legal Personal Representative) Date