<u>Assignment of Benefits/Authorization to Release Information/Authorization to Treat</u>

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

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 Centers for Medicare & Medicaid Services (CMS) and its agents, Champus/TRICARE and it agents or any other private or government insurance agency and/or 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 request that payment of Medicare, Medicaid or private insurance benefits be made to Capstone Orthopedic, Inc. for any covered services provided by Capstone Orthopedic, Inc. In addition, I agree to pay Capstone Orthopedic, Inc., the deductible and/or coinsurance due.

I am responsible and agree to pay for the following expenses: any service that my insurance deems non-covered or not medically necessary, all coinsurance/copayment amounts, all deductibles, any amount above the benefit limitations on my policy and any amount not covered because I was not insured at the time of service.

Furthermore, I verify that all the information provided by me is true, accurate and complete.

I acknowledge having received 1) a copy of Capstone Orthopedic Inc.'s Privacy Policy, 2) Capstone Orthopedic Inc.'s Financial Policy, 3) Medicare Supplier Standards, and 4) Warranty and Patient Responsibilities Information.

____ __________________________
Patient or Responsible Party Signature Date

____
Patient's Printed Name

If Responsible Party, please complete the following:

____
Printed Name

____
Address

Relationship to Patient: __________________________

Reason patient is unable to sign: ____

For Notice of Privacy Practices only, please describe the Responsible Party's authority to act on the behalf of the patient: ____