



Patient Registration HIPPA Signature Form

Patient Name _____

I understand that there are some circumstances that may require you to contact me regarding my care. By initialing and signing below, I authorize Lubbock Artificial Limb & Brace Ltd. to contact me at the following (please initial all that apply):

_____ Home Phone Number _____ Work Phone Number _____ Mobile Phone Number

We will leave voice messages when available. If you do not want information on any of the following to be left, please indicate by initialing.

_____ Appointments
_____ Treatment Instructions
_____ Billing/Account Information
_____ Other (please indicate) _____
_____ I do not want any voice messages left

I authorize Lubbock Artificial Limb & Brace, Ltd. to share information regarding my treatment, or payment for treatment, with the following individuals:

- ☐ My spouse or partner (name) _____
- ☐ My son or daughter (name) _____
- ☐ Other individual (name) _____
- ☐ None

I acknowledge that I have been offered a copy of Lubbock Artificial Limb & Brace, Ltd. Notice of Privacy Practices, dated January 2016.

I request that payment of authorized Medicare, Medicaid, or private insurance benefits be made to Lubbock Artificial Limb & Brace, Ltd. for any covered services furnished by Lubbock Artificial Limb & Brace, Ltd. I agree to pay to Lubbock Artificial Limb & Brace, Ltd. the deductible and/or coinsurance on my claim.

I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents, Champus/TRICARE and its agents, or to any private insurance company any information needed to determine these benefits or the benefits payable for related services.

X _____ Date _____
Signature of Patient or Responsible Party

X _____ Date _____
Signature of Representative (acknowledging receipt only)

Relationship to Patient _____

X _____ Date _____
Signature of Witness (if patient signing with a mark)

Printed Name of Representative or Witness _____

Address of Representative or Witness _____

Reason for Patient's Inability to Sign _____