(Patient's Name)

Assignment of Benefits/Authorization to Release Information

I request that payment of authorized Medicare, Medicaid, or private insurance benefits be made to Cotton Orthotic and Prosthetic Associates for any covered services furnished by Cotton Orthotic and Prosthetic Associates. I agree to pay to Cotton Orthotic and Prosthetic Associates the deductible and/or coinsurance on my claim.

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

I further certify that the information provided by me is true, accurate and complete.

If this is a private claim, I further agree to be responsible for the full amount of the charges from the date of delivery if my private insurance company does not pay for the charges in a timely manner, or my physician or I fail to provide within thirty (30) days the information necessary to submit the claim for payment.

By signing below, I acknowledge that I have received a copy of Cotton Orthotic and Prosthetic Associates Notice of Privacy Practices (NPP), dated March 1, 2012.

My signature below acknowledges that I have received Cotton's Main Patient Brochure which includes:

Welcome Letter	Mission Statement	Bill of Rights
Medicare Supplier Standards	Patient Responsibility	Warranty

Patient or Representative Signature: _____ Date: _____

If Representative, please complete below.

Printed Name: _____

Address: _____

Relationship to Patient: _____

Reason for the Patient's Inability to Sign: _____

For Notice of Privacy Practices only, describe the Representative's authority to act on behalf of the patient.

_____