ADVANCED PROSTHETIC SERVICES, INC.

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Searcy, AR 72143
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RELEASE OF MEDICAL INFORMATION AND ASSIGNMENT OF MEDICARE / MEDICAID / INSURANCE BENEFITS

I certify that the information given by me for payment by Medicare, Medicaid and/or any other Medical Insurance is correct. This form is used in lieu of the patient's signature on the "Request for Payment" HCFA- 1500 or other approved claim form and is, therefore an extension of that form. Anyone who misrepresents or falsifiesessential information in making Medicare or Insurance Claims may, upon conviction, be subject to fine and imprisonment under Federal Law.

I authorize any of my healthcare providers to provide my medical records/ information to Advanced Prosthetic Services as it relates to my medical history or my treatment. I further authorize the release of any medical or other information necessary to determine my insurance benefits or the benefits payable for related equipment or services to Advanced Prosthetic Services, Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration), my insurance carrier or other medical entity. A copy of this authorization will be sent to the Centers for Medicare and Medicaid Services, my insurance company or other entity if requested. The original authorization will be kept on file by the Advanced Prosthetic Services. I further permit a copy of this authorization to be used in place of the original.

I hereby authorize Advanced Prosthetic Services, Inc. to bill my health insurance entity(s) for any services I receive. I request that payment of authorized insurance benefits (primary or otherwise), including Medicare or Medicaid benefits, be made on my behalf directly to Advanced Prosthetic Services, Inc. for any equipment or services provided to me by its practitioners. In the event that insurance benefits for services provided are made directly to me, I will endorse and relinquish all checks for such payment to Advanced Prosthetic Services, Inc.

On assigned claims, the Advanced Prosthetic Services, Inc. agrees to accept the Medicare Carrier's allowable amount as the full charge for covered services. The patient is responsible for the deductible, co-insurance, and any non-covered services. I understand that I am financially responsible to the Advanced Prosthetic Services for any charges not covered by health care benefits. This authorization may be cancelled by mutual agreement of the provider and customer at any time by written notice to the Medicare Carrier.

It is my responsibility to notify the organization of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by Advanced Prosthetic Services and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for products received.

By signing below, I certify that I have read the foregoing and received a copy of Advanced Prosthetic Services Notice of Privacy Practices. I also certify that I am the patient or am duly authorized by the patient as the general agent to execute the above and accepted terms.

_____ _____ _____

Patient/ Spouse/ Guarantor/ Guardian Signature Relationship to Patient Date