ADVANCED PROSTHETIC SERVICES, INC.

2930 East Moore Avenue
Searcy, AR 72143
Phone: (501) 368-0868 Fax: (501) 368-0003

REQUEST OF PROVISION OF SERVICES

By signing this agreement, I indicate my wish to purchase Orthotic, Prosthetic, and/or Pedorthic devices, services or both from Advanced Prosthetic Services, Inc. I understand that my physician has prescribed the orthosis/prosthesis as part of my treatment. The potential benefits and limitations of the prescribed device(s) has been explained to me and any questions have been answered to my understanding. I also understand that due to the nature of the products supplied by Advanced Prosthetic Services, Inc., that they may not be returnable. I hereby give my informed consent and request Advanced Prosthetic Services provide the device my physician has prescribed.

INSURANCE AND FINANCIAL POLICY UNDERSTANDING

To prevent any misunderstanding about medical insurance, we wish to point out that:
(1) Payment for all medical services furnished are the responsibility of the patient; (2) Deductibles and/or co-payments are due at the time services are rendered; (3) Fifty percent (50 %) of the balance for non-covered custom-made devices is due at the time of cast and measurement, with the balance due at the time of delivery; (4) Advanced Prosthetic Services will bill your insurance company, however, we not responsible for non-payment from the insurance company; (5) If additional procedures and/or treatments are necessary beyond what has been previously approved, patients must make arrangements for payment; (6) Patients are expected to keep their accounts current. (7) Advanced Prosthetic Services will not provide or fabricate an item based on the fact that the patient wants the services only if his/her insurance will pay for them. Advanced Prosthetic Services can, in no way, guarantee insurance coverage. Benefits are determined by your insurance at the time your claim is processed. All benefit calculations are only an estimate, based on information obtained from your insurance company. The actual final Total Patient's Responsibility may be different than what we previously calculated**.**

AGREEMENT TO PAY

In consideration of Advanced Prosthetic Services undertaking to supply me with any products or services ordered by the patient or on the behalf of the patient, spouse, guarantor, and/or guardian agree that each of them is responsible for payment to Advanced Prosthetic Services, Inc. for all products and services provided to the patient, I agree to pay the balance due in full upon the receipt of a statement. I understand that Advanced Prosthetic Services, Inc. may add the maximum finance charge allowed by law to any unpaid balance, and may follow normal collection procedures.

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

_____	_____
Health Care Identification Number	Telephone Number