The Anaplastology Clinic

www.prostheticRx.com

2613 W. Carver St
Durham, NC 27705

T: 919.383.1205
F: 919.383.2838

PATIENT ACKNOWLEDGEMENT OF RECEIPT

office use only

PATIENT MRN# | | | | | | | | |

LAST NAME

FIRST NAME **MIDDLE NAME or INITIAL**

DATE OF BIRTH

M M D D Y Y Y Y

By signing below:

- I acknowledge receipt of the ***Notice of Privacy Practices*** document
- **If I am a Medicare patient:** I also acknowledge receipt of the Privacy Notice listed above AND these *additional* documents:
  1. Medicare DMEPOS Supplier Standards
  2. Patient Bill of Rights

Your signature below also provides AUTHORIZATION for the CLINIC

TO INVESTIGATE YOUR INSURANCE COVEREAGE AND FILE CLAIMS ON YOUR BEHALF

I hereby authorize *The Anaplastology Clinic, LLC* (TAC) to release any medical information necessary (TAC records and referring physician records) in order to secure prior authorization of treatment, submit insurance claims or appeal claim denials on my behalf. I authorize payment of medical benefits to be made directly to *The Anaplastology Clinic, LLC*. I authorize the use of this signature on all insurance claims, including electronic submissions. I understand that I am responsible for any and all fees not covered by my insurance.

SIGNATURE ... OF PATIENT or GUARDIAN

M M D D Y Y Y Y

If Guardian signs: **please fill out below - print neatly**

Last Name:	First:
Relationship to patient:	PHONE: