The Anaplastology Clinic

www.prostheticRx.com

2613 Carver St
Durham, NC 27705

T: 919.383.1205
F: 919.383.2838

PATIENT ACKNOWLEDGEMENT OF RECEIPT

PATIENT MRN#

LAST NAME | FIRST NAME | INITIAL

DATE OF BIRTH (MONTH / DAY / YEAR) | TODAY'S DATE (MONTH / DAY / YEAR)

ACKNOWLEDGEMENT OF RECEIPT

ALL PATIENTS

☐ I acknowledge receipt of the ***Notice of Privacy Practices*** in effect as of the date listed below.

SIGNATURE OF PATIENT / GUARDIAN — MONTH / DAY / YEAR

ADDITIONAL ***MEDICARE*** PATIENT INFORMATION

☐ I acknowledge receipt of the ***Medicare DMEPOS Supplier Standards*** on the below date.

SIGNATURE OF PATIENT / GUARDIAN — MONTH / DAY / YEAR

☐ I acknowledge receipt of the ***Patient Bill of Rights*** in effect as of the date listed below.

SIGNATURE OF PATIENT / GUARDIAN — MONTH / DAY / YEAR

AUTHORIZATION FOR CLAIMS

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 / GUARDIAN — MONTH / DAY / YEAR