





**EVER-CARE O P**  
**Privacy Practices Acknowledgment,**  
**Consents, and Assignment of Benefits**

**Acknowledgment of Receipt of Notice of Privacy Practices and Company Policies**

By signing below, I certify that Ever-Care has made available to me a Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of Ever-Care's healthcare operations. The Notice of Privacy Practices also describes my rights and Ever-Care's duties with respect to my protected health information. Ever-Care reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, or asking for one at the time of my next appointment.

**Consent for Contact**

I, the undersigned, consent to be contacted by Ever-Care by phone call, e-mail, US Postal Service or other means to follow-up on my care.

**Use of Images**

By signing below, I understand that Ever-Care may use my likeness in a photograph or video as part of its marketing efforts including but not limited to publication in external communication and social media posts. I waive the right to inspect or approve the finished product wherein my likeness occurs. Additionally, I waive any right to royalties or other compensation related to the use of those images.

**Consent to Provide Services and/or Products**

I understand that by signing this agreement, I indicate my wish to purchase orthotic and/or prosthetic products or services, or both, from Ever-Care. I understand that I am under the supervision and care of my attending physician. I understand that my physician has prescribed the orthosis/prosthesis noted as part of my treatment. I also understand that due to the nature of the products supplied by Ever-Care that they cannot be returned.

**Assignment of Benefits**

I, the undersigned, hereby authorize Ever-Care to request on my/our behalf and to collect directly all public and private insurance benefits due for products and/or services supplied to me by Ever-Care. In the event payments for insurance benefits are made directly to any of the undersigned, the payee will endorse to Ever-Care all checks for such payments.

**Consent to Coordinate Care and Release of Medical Records**

By signing below, I authorize all medical personnel to provide information to Ever-Care concerning my medical history, as it may relate to my treatment. This includes collecting medical information from any physician, surgeon, medical facility and/or physical therapist seen by me. Ever-Care will comply with all HIPAA rules and regulations.

**Insurance Coverage**

By signing below, I agree to inform Ever-Care of any changes in my insurance coverage. If my insurance coverage changes or is terminated, I understand that I am responsible for all charges of services and devices delivered to me or in fabrication.

Patient Name Printed

Patient Date of Birth

Patient/Guardian Signature

Date

Guardian Printed Name

Relationship to Patient

