DAYTON ARTIFICIAL LIMB
Lower Extremity Specialists

DAYTON PHYSICAL THERAPY
Lower Extremity Specialists

Medicare DMEPOS Supplier Standard Signature Form

Consent for Purposes of Treatment, Payment and Healthcare Operations

By signing this form, I consent to the use or disclosure of my protected health information by **Dayton Artificial Limb/Dayton Physical Therapy** for the purpose of providing treatment to me, obtaining payment for my health care bills or to conduct **DALC/DPTC** health care operations. I understand that I have the right to revoke this consent, in writing, at any time, except to the extent that **DALC/DPTC** has taken action in reliance on my prior consent.

My "protected health information" means any of my written and oral health information, including my demographic data that can be used to identify me, that has been created or received by **DALC/DPTC**, and that relates to my past, present or future physical or mental health or condition.

I understand I have a right to review **DALC/DPTC** Notice of Privacy Practices prior to signing this document. 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 our health care operations. The Notice of Privacy Practices also describes my rights and **DALC/DPTC** duties with respect to my protected health information. The Notice of Privacy Practices is posted in **(7637 North Main Street, Dayton, OH 45415).**

As noted in **DALC/DPTC** Notice, **DALC/DPTC** reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I understand that I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, asking for one at the time of my next appointment.

I understand I have the right to request restrictions as to how my protected health information is used or disclosed to carry out treatment, payment or our healthcare operations. **DALC/DPTC** is not required to agree to the restrictions that I may request, but if it does, it is bound by its agreement.

I understand that diagnosis or treatment of me by **DALC/DPTC** may be conditioned upon my consent as evidenced by my signature on this document.

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Acknowledgement of Receipt of Notice of Privacy Practices

I certify that I have received a copy of **Dayton Artificial Limb/Dayton Physical Therapy** 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 **DALC/DPTC** health care operations. The Notice of Privacy Practices also describes my rights and **DALC/DPTC** duties with respect to my protected health information. The Notice of Privacy Practices is posted in **(7637 North Main Street, Dayton, OH 45415).**

Dayton Artificial Limb/Dayton Physical Therapy 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, asking for one at the time of my next appointment.

Authorization for Use or Disclosure of Information for Purposes Requested by Dayton Artificial Limb

I hereby authorize Dayton Artificial Limb/Dayton Physical Therapy to use the following protected health information, and/or disclose the following protected health information to the person/persons indicated in my medical chart.

This authorization shall be in force and effect ***continually*** until which time this authorization to use or disclose this protected health information is revoked or expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to **Office Administrator at 7637 North Main Street, Dayton, OH 45415.** I understand that a revocation is not effective to the extent that **Dayton Artificial Limb/Dayton Physical Therapy** has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

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I understand that I have the right to

- Inspect or copy my protected health information to be used or disclosed
- As permitted under federal law (or state law to the extent the state law provides greater access rights.) refuse to sign this authorization.

Dayton Artificial Limb/Dayton Physical Therapy will not condition my treatment on whether I provide authorization for the requested use or disclosure, except under the following circumstance:

- When the provision of health care by **DALC/DPTC** is solely for the purpose of creating protected health information for disclosure to a third party, when such disclosure is contingent upon my authorization.

[The use or disclosure requested under this authorization will result in direct or indirect remuneration to **DALC/DPTC** from a third party.]

For Medicare patients only--I have received a copy of the Medicare DMEPOS Supplier Standards and **DALC/DPTC** Equipment Warranty Information forms.