ORTHOTICS & PROSTHETICS

*Quality Since 1988*

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# TREATMENT CONSENT FORM

Patient Name:____________________________Medical Record No:_______________

I hereby consent to treatment in accordance with my doctor's prescription and authorize
Collier Orthotics and Prosthetics to release medical information necessary to process this claim. I also authorize the payment benefits be made directly to Collier Orthotics and Prosthetics until my account is paid in full. Accounts not paid ninety (90) days after product delivery will be subject to collection. In order to facilitate treatment initiation, a faxed copy of this form shall be acceptable. This consent is in effect for one (1) year or until revoked in writing.

_______________________________________________________________

Signature of Patient, P.O. A., Responsible Party, Facility Representative

____________________

Date

Address of Signer: ______________________________________________________________

Phone Number: _________________________________________________________________

Renewals as Required: ___________________________________________________________

1:______________________________________________________________________

2:______________________________________________________________________

3:______________________________________________________________________

4:______________________________________________________________________

5:______________________________________________________________________

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