

**Acknowledgement of Financial Responsibility, Benefits and Medical Information Release**

**Authorization:**

I authorize all providers, care givers and payers to release any information necessary to provide services or process claims to Charleston Brace Co., LLC. I request that my insurance benefits, if any, be paid directly to Charleston Brace Co., LLC or its assigns. I understand that I am responsible for any balance not paid or covered by my insurance company and that prior authorization or pre-approval by my insurance company is not a guarantee of payment. I agree to pay any and all amounts remaining due for the services provided by Charleston Brace Co., LLC. The above information is true and correct to the best of my knowledge and I agree to provide updated information if there are any changes. By my signature, I agree to the above terms and conditions and acknowledge receipt of Charleston Brace Company's Privacy Practices.

Signature\_\_\_\_\_

Date\_\_\_\_\_

\*See Product Safety Standards.\*

Charleston Brace Co., LLC, prior to dispensing, distributing, or delivering items to a patient, will verify, authenticate, and document, in the form of purchase orders, that the items are not adulterated, counterfeit, suspected of being counterfeit, and have not been obtained by fraud or deceit and are not misbranded and are appropriately labeled for their intended distribution channels by way of only utilizing orthotic/prosthetic equipment/items from reputable manufactures that provide copies of features, warranties and instructions for each type of non-custom fabricated item(s).