PATRIOT PROSTHETICS and ORTHOTICS, INC.

405-577-6778 office 405-577-6799 fax

patriotprosthetics@yahoo.com

Michael Huggins, CEO, CP, LPO Dallas Curtis, CFO, CPO, LPO

TREATMENT CONSENT FORM

Patient Name: _____ Medical Records Number_____

I hereby consent to treatment in accordance with my doctor's prescription and authorize Patriot Prosthetics and Orthotics, Inc. to release medical information necessary to process this claim. I also authorize the payment benefit be made directly to Patriot Prosthetics and Orthotics, Inc. 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 (please circle)

Date:_____

Address of Signer:_____

Phone number:_____

Renewals as Required:_____

1)_____ 2) _____

3)_____ 4)_____

5)_____ 6)_____