

WARRANTY POLICY

The warranty period for custom prostheses is three months for workmanship and materials. Although Perry Prosthetics, Inc. cannot be responsible for physiological or anatomical changes in a patient's medical condition, we will attempt to maintain a proper fit during this period. Normal adjustments to enhance fit will be made at the discretion of the practitioner at no charge for up to three months after delivery of the device. There will be a chance for adjustments or repairs that are made as a result of physiological or anatomical changes, as well as abuse or tough wear. Additions of components prescribed by a physician will incur a charge. Prostheses are described at the direction of a physician and are custom fabricated. They cannot be returned for credit or refund. Prescribed "off the shelf" items cannot be returned for hygienic reasons. Please communicate any problems or discomfort you are experiencing to your practitioner immediately.

PAYMENT POLICY

Perry Prosthetics, Inc. will bill your insurance company as a courtesy to you; however, we are not responsible for non-payment from the insurance company. Payment for all medical services furnished are the responsibility of the patient. Deductibles, co-insurance and payment for noncovered services are due upon receipt of invoice. If you are unable to pay your balance in full, we will work with you personally to develop a payment plan consisting of monthly payments that suit your financial means. Perry Prosthetics, Inc. can in no way guarantee coverage. Benefits are determined by your insurance at the time your claim is processed. It is your responsibility to know your benefits. We strongly advise you to contact your insurance company to check your benefits/coverage. Payments may be made by cash, check, credit card or money order.

PATIENT APPOINTMENTS

Patient care is the top priority at Perry Prosthetics, Inc. to better accommodate our patients, return and follow up appointments will be scheduled at the end of each appointment. If you must cancel or reschedule an appointment, we ask that you do so as far in advance as possible. If an appointment is missed without prior notification, the patient will be billed at \$45.00 missed appointment fee.

PATIENT COMPLAINT PROCESS

We are committed to ensuring you are completely satisfied with the services and care you receive at Perry Prosthetics, Inc. however, if for any reason you wish to file a complaint, any staff member can assist you in this confidential matter. You will be asked to complete a "Patient Complaint Form" to assist us in understanding your complaint. Once the form is received, a company representative will investigate the complaint thoroughly and take the necessary actions to satisfy your complaint.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES & SUPPLIER STANDARDS

I certify that I have reviewed a copy of Perry Prosthetics, Inc. Notice of Privacy Practices. The Notice of Privacy Practices describes the type of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of Perry Prosthetics, Inc. health care operations. The Notice of Privacy Practices also describes my rights and Perry Prosthetics, Inc.'s duties with respect to my protected health information. Perry Prosthetics, Inc. reserves the right to change their 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 copy be sent by mail or asking for one at the time of my next appointment. I acknowledge that I have received a copy of the Medicare Supplier Standards.

ASSIGNMENT OF BENEFITS

I hereby authorize Perry Prosthetics, Inc. to release necessary medical information to my insurance to process my medical claims. I authorize my insurance carrier to pay benefits directly to Perry Prosthetics, Inc.

I requested that payment of authorized Medicare benefits be made to Perry Prosthetics, Inc. on my behalf for any services furnished by me by Perry Prosthetics, Inc. I authorize any holder of medical or other information about me to be released to the Center of Medicare & Medicaid Services and its agents to determine these benefits. As the responsible party, I understand that I am personally responsible for the entire amount of my claim and that insurance benefits may be limited or non-existent.

PERMISSION TO CONTACT

I give written permission to Perry Prosthetics, Inc. to contact me by telephone. This includes any timeframe beyond 15 months after receiving a device or related supplies.

I, the undersigned, have read and understand these policies and agree to all of the above.

SIGNATURE OF RESPONSIBLE PARTY

DATE

Patient 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 Perry Prosthetics, Inc. for the purpose of providing treatment to me, obtaining payment for my health care bills or to conduct Perry Prosthetics, Inc.'s health care operations. I understand that I have the right to revoke this consent, in writing, at anytime, except to the extent that Perry Prosthetics, Inc. 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 Perry Prosthetics, Inc., and that relates to my past, present or future physical or mental health condition.

I understand I have a right to review Perry Prosthetic, Inc.'s Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the type 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 is posted in the lobby of Perry Prosthetics, Inc. and on Perry Prosthetics, Inc.'s website at www.perryprosthetics.com.

As noted in Perry Prosthetics, Inc.'s Notice of Privacy Practices, Perry Prosthetics, Inc. 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, or accessing Perry Prosthetics, Inc.'s website.

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 health care operations. Perry Prosthetics, Inc. is not required to agree to the restrictions that I may request, but if does, it is bound by its agreement.

I understand that diagnosis or treatment of me by Perry Prosthetics, Inc. may be conditioned upon my consent as evidenced by my signature on this document.

Patient Name

Signature

Date