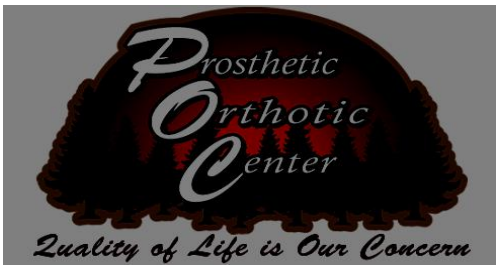

PATIENT INFORMATION

NAME: (LAST, FIRST) _____

ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

HOME PHONE:_____ CELL PHONE:_____

DATE OF BIRTH:_____ SOCIAL SECURITY #:_____

EMERGENCY CONTACT NAME:_____ PHONE#:_____

PERSON AUTHORIZED FOR DISCLOSURE OF INFO:

NAME:_____PHONE #:_____

Benefits, Medical Information Release Authorization and Acknowledgment of Financial Responsibility:
I request that payment of authorized Medicare and/or insurance benefits be made on my behalf to **Prosthetic Orthotic Center** for any services furnished to me by this provider. I authorize any hold of medical information about me to release to the Health Care Financing Administration and it's agents and any information needed to determine these benefits payable for related services. 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. I also understand that after a certain amount of time of non-payment (if patient responsibility) **Prosthetic Orthotic Center** has the right to enlist a creditor. I agree to notify **Prosthetic Orthotic Center** immediately of any changes in insurance coverage or status. This authorization is in effect until I choose to revoke it.

Patient/Representative's Signature: Date:

I certify that I have received a copy of **Prosthetic Orthotic Center's** Notice of Privacy Practices. The Notice of Privacy 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 **Prosthetic Orthotic Center's** health care operations. The notice of Privacy Practices also describes my rights and **Prosthetic Orthotic Center's** duties with respect to my protected health information.
Prosthetic Orthotic Center 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 to be sent in the mail or asking for one at the time of my next appointment.
Prosthetic Orthotic Center also reserves the right

Patient/Representative's Signature: Date:

EMPLOYEE USE ONLY:

Yearly Information Update (year & initials):_____ _____ _____ _____ _____ _____