PONGRATZ ORTHOTICS & PROSTHETICS, INC.

Patient Consent for Purposes of Treatment, Payment, and Healthcare Operations Pongratz Orthotics & Prosthetics, Inc. ("FACILITY")& Acknowledgment of Receipt of Notice of Privacy Practices

Patient Consent:

By signing this form, I consent to the use or disclosure of my protected health information by **FACILITY** for the purpose of providing treatment to me, obtaining payment for my health care bills or to conduct **FACILITY's** health care operations. I understand that I have the right to revoke the consent, in writing, at any time, except to the extent that the **FACILITY** 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 **FACILITY**, and that relates to my past, present or future physical or mental health or condition.

I understand I have a right to review **FACILITY's** Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices 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 our health care operations. The Notice of Privacy Practices also describes my rights and **FACILITY's** duties with respect to my protected health information. The Notice of Privacy Practices is posted in the front lobby and on **FACILITY's** website, if available.

As noted in **FACILITY's** Notice, **FACILITY** 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 **FACILITY'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 healthcare operations. **FACILITY** is not required to agree to the restriction that I may request, but if it does it is bound by its agreement.

I understand that diagnosis or treatment of me by **FACILITY** may be conditioned upon my consent as evidenced by my signature on this document.

Patient Acknowledgment:

I certify that I have received a copy of **FACILITY's** Notice of Privacy Practices. The Notice of Privacy Practices 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 **FACILITY's** health care operations. The Notice of Privacy Practices also describes my rights and **FACILITY's** duties with respect to my protected health information. The Notice of Privacy Practices is posted in the front lobby and on **FACILITY's** website, if available.

FACILITY 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 be sent in the mail, asking for one at the time of my next appointment, or accessing **FACILITY's** website.

AUTHORIZATION:
I hereby authorize the release of information regarding my/the patient's condition/treatment, as necessary to process this and/or related claims. **I understand that I am responsible for all fees not covered by insurance, Medicare, Medical Assistance or other Governmental Agencies, or Worker's Compensation.**

MEDICARE DMEPOS SUPPLIER STANDARDS

The products and/or services provided to you by Pongratz Orthotics & Prosthetics are subject to the supplier standards contained in the Federal regulations shown at 42 Code of Federal Regulations Section 424.57(c). These standards concern business professional and operational matters (e.g. honoring warranties and hours of operation). The full text of these standards can be obtained at http://ecfr.gpoaccess.gov. Upon request we will furnish you a written copy of the standards.

_____ _____
Printed Patient Name DOB

_____ _____
Signature of Patient or Guardian Date