ACKNOWLEDGEMENT OF RECEIPT OF SUMMARY OF PRIVACY PRACTICES FROM CENTER FOR PROSTHETICS ORTHOTICS

I certify that I have received a copy of **CPO's** Summary of Privacy Practices. This Summary 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 **CPO's** health care operations. This Summary also describes my rights and **CPO's** duties with respect to my protected health information. The complete Notice of Privacy Practices is posted in the **CPO** waiting room and on **CPO's** website at www.cpo.biz. A complete copy of the Notice of Privacy Practices may be requested from the receptionist.

CPO 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 **CPO**'s website.

ACKNOWLEDGEMENT OF RECEIPT OF MESSAGE FROM TRICARE

My signature only acknowledges my receipt of the Tricare message (if applicable) from CENTER FOR PROSTHETICS ORTHOTICS, INC. and does not waive any of my rights to request a review or make me liable for any payment.

NOTICE OF PRIVACY RESTRICTIONS

Our Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Your "protected health information" means any of your written and oral health information, including your demographic data that can be used to identify you. This health information that is created or received by your health care provider, and that relates to your past, present or future physical or mental health condition.

This Notice will let you know about the various ways we use and disclose your medical information, describe your rights and our obligations with respect to the use or disclosure of your medical information. We will also ask that you acknowledge receipt of this Notice the first time you come to or use any of our facilities, because the law requires us to make a good faith effort to obtain your acknowledgement.

We are required by law to: Make sure that any medical or health information that we have that identifies you is kept private and will be used or disclosed only in accord with our Notice of Privacy Practices and applicable law;
Give you and complete Notice of our legal duties and our Privacy practices and
Abide by the terms of the Notice of Privacy Practices that is in effect from time to time.

PRIVACY RESTRICTIONS

Please check off:

- ☐ Do not phone at home
- ☐ Send all mail to alternate address
- ☐ Do not leave messages on answering machine or voice mail
  - ☐ At home
  - ☐ On Cell
- ☐ Do not leave message with individual other than patient
- ☐ Do not mail reminder postcards
- ☐ Other privacy request
- ☐ Restrict communication to the following individuals regarding my treatment and/or appointments. (OK to speak with)

➢ ____
Name Relationship

➢ ____
Name Relationship

➢ ____
Name Relationship

I have read and understand <u>Privacy Practices</u>; <u>Medicare Supplier Standards</u> (copy received/read); <u>Privacy Restrictions</u> and <u>Tricare message</u> (if applicable).

____ ______________
Patient's Signature Date

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NOTE: IF PATIENT IS UNABLE TO SIGN, PLEASE COMPLETE THE FOLLOWING:		
***AUTHORIZED PATIENT REPRESENTATIVE DOCUMENTATION**		
I,_________________________,have signed as patient representative for ______________________.		
Name of patient representative		Patient name
Reason the patient is unable to sign:____.		
___________________________________	__________________	_____________________
Signature of patient representative	Relationship	Phone with area code
Street address	City, State and Zip Code	