

Acknowledgement of Receipt of Notice of Privacy Practices

I certify that I have received a copy of **ALLIED ORTHOTICS AND PROSTHETICS'** 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 **ALLIED ORTHOTICS AND PROSTHETICS'** health care operations. The Notice of Privacy Practices also describes my rights and **ALLIED ORTHOTICS AND PROSTHETICS'** duties with respect to my protected health information. The Notice of Privacy Practices is posted in the patient waiting room and on **ALLIED ORTHOTICS AND PROSTHETICS'** website at **www.alliedoandp.com**.

ALLIED ORTHOTICS AND PROSTHETICS 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 **ALLIED ORTHOTICS AND PROSTHETICS'** website.

Signature of Patient or Personal Representative

Name of Patient or Personal Representative

Date

Description of Personal Representative's Authority

Acknowledgement of Receipt of Medicare Standards for DMEPOS Suppliers

Date

Signature of Patient or Personal Representative

Description of Personal Representative's Authority