Premier Prosthetics

Acknowledgment Form

I understand that as part of my healthcare, Premier Prosthetics originates and maintains health records describing my health history, examination, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and treatment to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of Protected Health Information uses and disclosures. I understand that I have the right to review the Notice of Privacy Practices prior to signing this acknowledgement. I understand that Premier Prosthetics reserves the right to change its practices and to make the new provisions effective for all Protected Health Information maintained by them.

I understand that I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Premier Prosthetics is not required to agree to the restrictions requested. They will not use or disclose your health information without your authorization, except as described in the Notice of Privacy Practices.

Their records may contain information created by an entity other than their practice. Premier Prosthetics is not responsible for the information contained therein (including the accuracy, completeness, relevance, legibility or lack thereof such incorporated records). Patient expressly requests release of all records maintained by Premier Prosthetics concerning patient, including incorporated records. Patient acknowledges that they have no and assumes no duty to patient regarding the content of or omissions from such incorporated records.

Printed Name of Patient ______________________________

Signature of Patient or Legal Representative _______________________________ Date _______________________