



CENTER FOR PROSTHETICS ORTHOTICS PATIENT REGISTRATION FORM

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.

Please sign and date at end of form...

Do not sign here _____

PATIENT'S SIGNATURE OR PERSONAL REPRESENTATIVE*

RECEIPT OF MEDICARE SUPPLIER STANDARDS DOCUMENTATION

I have received a copy of the **CMS MEDICARE DMEPOS SUPPLIER STANDARDS**, which every durable medical equipment and prosthetic-orthotic supplier must meet to obtain and retain their billing privileges.

Please sign and date at end of form...

Do not sign here _____

PATIENT'S SIGNATURE OR PERSONAL REPRESENTATIVE*

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.

Please sign and date at end of form...

Do not sign here _____

PATIENT'S SIGNATURE OR PERSONAL REPRESENTATIVE*

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 Privacy Practices; Medicare Supplier Standards (copy received); Privacy Restrictions and Tricare message (if applicable).

SIGNATURE: _____ **DATE:** ____ / ____ / ____

TYPING YOUR FULL NAME HERE ACTS AS A DIGITAL SIGNATURE

NOTE: IF PATIENT IS UNABLE TO SIGN, PLEASE COMPLETE THE FOLLOWING:

AUTHORIZED PATIENT REPRESENTATIVE DOCUMENTATION

I, _____, have signed as patient representative for _____.

REPRESENTATIVE NAME PATIENT NAME

Reason patient is unable to sign: _____

SIGNATURE OF PATIENT REPRESENTATIVE

RELATIONSHIP

PHONE WITH AREA CODE

STREET ADDRESS

CITY, STATE AND ZIP