

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF
PRIVACY PRACTICES AND/OR MEDICARE
SUPPLIER STANDARDS**

I certify that I have received a copy of the **SCOPE Orthotics & Prosthetics, Inc.** 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 **SCOPE's** health care operations. The Notice of Privacy Practices also describes my rights and **SCOPE's** duties with respect to my protected health information. The Notice of Privacy Practices is posted in each **SCOPE** office.

SCOPE 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 or asking for one at the time of my next appointment.

If you would like to grant permission to SCOPE Orthotics & Prosthetics, Inc. to discuss your Protected Health Information (PHI) with a relative, associate or friend, please inform us. If you wish your designated person (s) to have full access to all your information or partial access to your information please check the appropriate box and indicate the person's name under the selected box. **If you don't want any information given to anyone, simply sign your name without checking a box and listing a name.**

| | | |
|---|---|---|
| <input type="checkbox"/> All My Information | <input type="checkbox"/> Medical Information Only | <input type="checkbox"/> Financial Information Only |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Signature of Patient or Personal Representative

Name of Patient or Personal Representative

Date

Description of Personal Representative's Authority

As a Medicare patient I also acknowledge that I have been provided a copy of the "Supplier Standards".

Signature of Patient or Personal Representative