ACKNOWLEDGMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

With my consent, Foot and Heel Pain Institute of Michigan may e-mail, call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations. Such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

The person named below (hereinafter called "Patient") consents that Foot and Heel Pain Institute of Michigan, its health care providers, clinical and technical employees, consulting physicians, residents or any assistants, whom they may call to their aid, may administer any treatment deemed advisable in the care and treatment of the patient. The patient also consents to all procedures, that whether for diagnosis or treatment prior to or during the procedure may be deemed advisable in their care and treatment. Patient further understands that no guarantee of assurance has been made as to the results that may be obtained.

If you would like to give consent for a designated party to be contacted or to call on your behalf, please list this patient below.

____

Patient Name (please print)

____

Parent or Authorized Representative (if applicable)

____

Designated Party/ Print Name

_______________________________________ ______________________

Signature Date