Hittenberger Orthotics & Prosthetics, LLC
181 Lynch Creek Way, Suite 101
Petaluma, CA 94954
www.hittenberger.com
707-765-1122 415-499-1122
FAX 707-765-4571

Patient Name: _____

Acknowledgement of Receipt of Notice of Privacy Practices

I certify that I have received a copy of Hittenberger Orthotics and Prosthetics, LLC, 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 Drew Hittenberger & Associates health care operations. The notice of Privacy Practices also describes my rights and Drew Hittenberger & Associates duties with respect to my protected health information. The notice of Privacy Practices is posted at 181 Lynch Creek Way, Suite 101, Petaluma, CA 94954.
Drew Hittenberger & Associates 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 Practice by calling the office and requesting a revised copy be sent in the mail, or by asking for one at the time of my next appointment.

X _____
Signature of Patient or Personal Representative Witness Date

Photographic Consent

Authorize any photographing of myself (the patient) in connection with diagnosis and treatment as determined by Hittenberger Orthotics and Prosthetics, LLC for educational purposes. Photographs may be used for visual presentations to physicians, hospitals, ancillary health educational training programs, and are incorporated with the patient's medical record for documentation of care, and may be used in conjunction with articles in medical or scientific publications. My name (or name of the fore mentioned patient) shall not be used to identify photography, outside of the medical record. I authorize Drew Hittenberger and Associates to contact me by telephone for any follow up treatment required.

I hereby certify that I have read and fully understand the above provisions.

X _____
Signature of Patient or Personal Representative Witness Date

If the patient is unable to consent because (A) the patient is a minor _____ years of age or (B) other reason _____

The undersigned (acting on behalf of all patients and guardians), certifies that the undersigned is a parent or legal guardian and has full and complete authority from said patient's other parent or legal guardian(s) to give the above consent and make the representations hereunder on their behalf.

X _____
Signature of Parent or Guardian Witness Date