Acknowledgement of Receipt of Notice of Privacy Practices

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

_____	_____
Patient Name (please print)	Parent or Authorized Representative (if needed)
_____	_____
Signature	Date

Acknowledgement of Receipt of Financial Policy

I acknowledge that I was provided a copy the financial policy for Restoration Foot & Ankle, PLLC, and I understand the terms set forth in the document.

_____	_____
Patient Name (please print)	Parent or Authorized Representative (if needed)
_____	_____
Signature	Date

Request for Confidential Communications

I, _____, give permission to Restoration Foot & Ankle, PLLC, to discuss my medical and/or billing information with the following persons either by oral communication or written communication, whichever is appropriate at the time:

1. _____
2. _____
3. _____

_____	_____
Patient Name (please print)	Patient Date of Birth
_____	_____
Patient Signature	Date